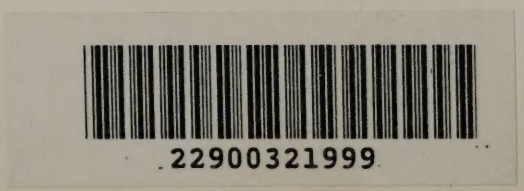
medical malpractice

REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE



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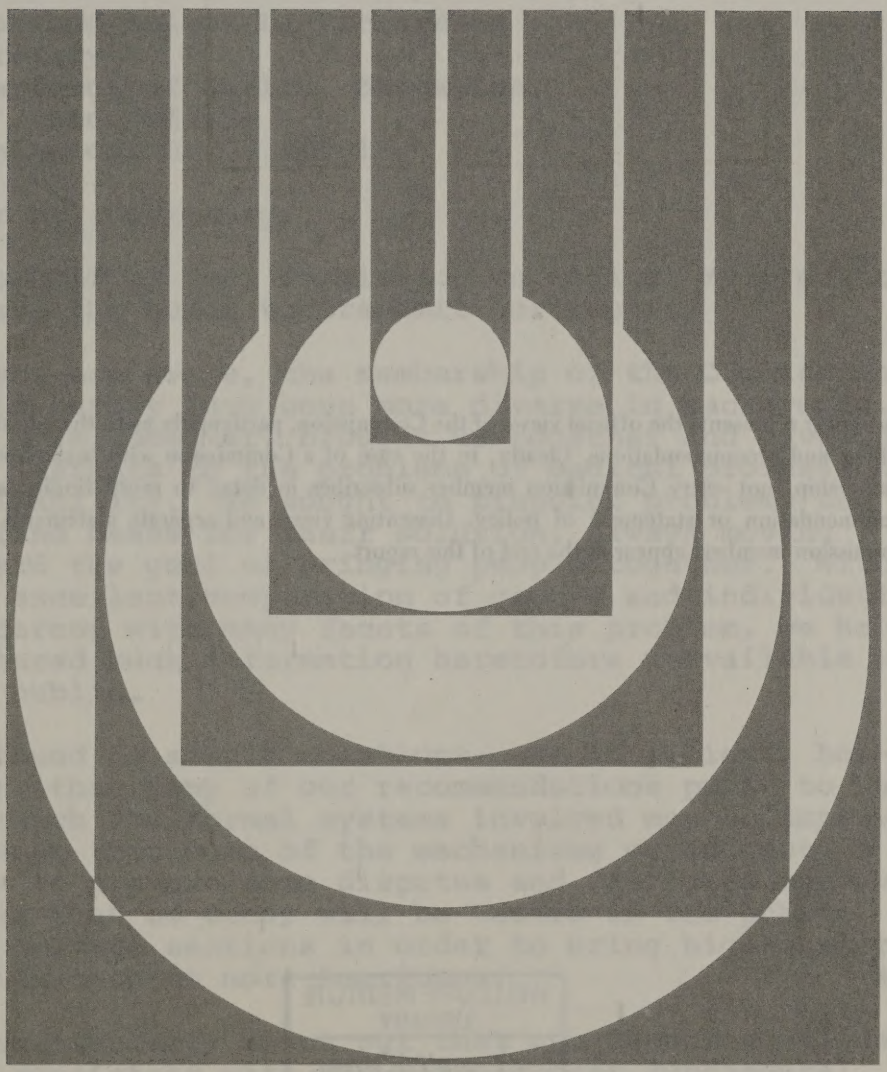

JANUARY 16, 1973

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C.

DHEW PUBLICATION NO. (OS) 73-88

This report represents the official views of the Commission, particularly as to the adopted findings and recommendations. Clearly, in the case of a Commission with such diverse membership, not every Commission member subscribes in detail to every finding and recommendation or statement of policy. Dissenting views and separate statements of Commission members appear at the end of this report.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

January 16, 1973

SECRETARY'S COMMISSION
ON
MEDICAL MALPRACTICE

Honorable Elliot L. Richardson
Secretary
Department of Health, Education,
and Welfare
Washington, D. C. 20201

Dear Mr. Secretary:

On behalf of your Commission on Medical Malpractice, I have the honor to transmit our report.

As you are aware, the membership of the Commission could hardly have been more diverse in background. Our work, however, brought us together and gave us new insights to the problems of medical professional liability. We sought to pinpoint problems and to find means for their solution, always moving toward the goal of bringing people together. With the excellent cooperation of groups and individuals concerned with many facets of this problem, we have gathered much information heretofore unavailable to the public.

We found no simple solutions. We do believe, however, that many of our recommendations point to ways in which the formal systems involved may be improved. We hope that some of the mechanisms we suggest as aids to prevent some disputes and fairly to resolve those that do occur will be tested in the public and private sections in order to bring high-quality health care to more Americans.

We particularly point out that our recommendations are consistent with our concern that fundamental legal rights of health-care providers and patients continue to be protected. Of special concern are the rights of those persons who are unable effectively to protect themselves, including the unsophisticated poor and near poor, the mentally retarded, the institutionalized aged, prisoners, patients in mental hospitals and children.

It has been a pleasure for us to work together and a privilege and an honor to have served on your Commission. We hope that the results of our efforts will prove to be of value, and that the Commission's findings and recommendations will stimulate both thoughtful debate and decisive action.

Sincerely,

Wendell G. Freeland

Wendell G. Freeland
Chairman

The Commission

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VINCENT H. COHEN, Washington, D.C.—Trial attorney and partner in the Washington, D.C. law firm of Hogan & Hartson. Mr. Cohen has over four years experience in the Justice Department's Medical Malpractice unit as a trial attorney.

BERNARD J. CONWAY, Chicago, Illinois—Attorney; Assistant Executive Director of the American Dental Association for Legislation and Legal Affairs and Secretary of the Council on Legislation; has been responsible for handling malpractice liability and prevention activities for the A.D.A. during the past 10 years. Mr. Conway publishes a column covering malpractice cases in the monthly *Journal of the American Dental Association.*

HELEN CREIGHTON, Milwaukee, Wisconsin—Professor of Nursing, University of Wisconsin, Milwaukee; a nursing educator with a law degree and extensive background in the legal aspects of nursing practice; a widely recognized authority on malpractice law. Dr. Creighton has authored several books and articles on the subject of malpractice, serves as a consultant to *Supervisor Nurse* in which she has a monthly legal column on nursing practice and is a nursing practice advisor to *Nursing '72.*

WILLIAM J. CURRAN, Boston, Massachusetts—Lee Professor of Legal Medicine, Harvard Medical School; a recognized authority on health law; past President of the Massachusetts Public Health Association and serves as legal counsel to United Health Foundations, Inc., New York; The Medical Foundation, Inc., Boston; and College Mental Health Center of Boston, Inc.

WENDELL G. FREELAND, Pittsburgh, Pennsylvania—Chairman of the Secretary's Commission on Medical Malpractice. A practicing attorney, Mr. Freeland is Trustee and Senior Vice-President of the National Urban League; Director and former President of the Urban League of Pittsburgh; member, Board of Governors of Joint Center for Political Studies.

HOWARD HASSARD, San Francisco, California—Attorney and partner in the San Francisco law firm of Hassard, Bonnington, Rogers & Huber; an experienced defense lawyer representing physicians; general counsel for the California Medical Association and a number of other medical and health-related associations. Mr. Hassard has been engaged in the medical malpractice field since 1934 and is the author of several articles on the subject.

ELIZABETH ANN HIDDING, Minneapolis, Minnesota—A graduate of the College of St. Catherine in the field of social service. Mrs. Hidding is presently an executive officer of Twin City Tile and Marble Company, Minneapolis; President of the Board of Directors of St. Therese Nursing Home for the Aged; Director of the Christ Child Services for Mentally Retarded; and a member of the Board of Trustees of St. Thomas College in St. Paul, Minnesota.

CHARLES A. HOFFMAN, Huntington, West Virginia—a practicing urologist; President of the American Medical Association, Past-President of the American Urological Association and the American Association of Clinical Urologists; past chairman of the AMA's Committee on Professional Liability and author of numerous articles on Professional Liability as it relates to the medical profession.

PAUL B. JARRETT, Phoenix, Arizona—Surgeon and pathologist; past chairman of the Arizona Medical Association's Malpractice Committee and past President of the Arizona Medical Association; author of a pamphlet on the malpractice problem entitled, "Where Will it All End?", and also a booklet about children's accidents, "What's the Answer?"

HENRY T. KRAMER, Rye, New York—President and Director, North American Reinsurance Corporation, New York, N.Y.; graduate of Yale University; associated with the reinsurance industry since 1946 and has had wide experience in the malpractice area as president of one of the nation's largest reinsurers.

JOHN E. LINSTER, Wausau, Wisconsin—Graduate of Washington University Law School; Senior Vice-President of Employers Insurance of Wausau; member of the American Bar Association, Missouri Bar Association, Wisconsin Bar Association, and the International Association of Insurance Counsel. Mr. Linster has had extensive experience with malpractice insurance, particularly the New York Medical Society Malpractice Insurance Program.

JAMES E. LUDLAM, Los Angeles, California—Partner in the Los Angeles law firm of Musick, Peeler and Garrett, and a recognized authority on malpractice law; General Counsel for the California Hospital Association and General Counsel for some 100 hospitals and special counsel to more than 50 others. Mr. Ludlam is past President of the American Society of Hospital Attorneys and is a writer and frequent lecturer on malpractice.

RICHARD M. MARKUS, Cleveland, Ohio—A *cum laude* graduate of Harvard Law School; Past President of the American Trial Lawyer's Association; active trial practitioner and author of numerous articles on personal injury litigation. Mr. Markus is a Trustee and faculty member for The National Institute for Trial Advocacy and The National Advocacy College, and an Adjunct Professor of Law at Cleveland State University Law School.

EDWARD H. MORGAN, Hartford, Connecticut—A Yale University graduate; Secretary (Underwriting), Aetna Casualty and Surety Company; has handled the underwriting of professional liability insurance for over 25 years. Mr. Morgan has had wide experience in the malpractice insurance market, and lectures on insurance matters.

GEORGE W. NORTHUP, Livingston, New Jersey—Former President of the American Osteopathic Association and the present Editor of its journal; has served on the A.O.A. Bureau for three years dealing with professional liability problems of osteopathic physicians; and has been Treasurer of the National Health Council for the past eight years. Dr. Northup has authored many articles and a book on osteopathic medicine.

AUDRA MARIE PAMBRUN, Helena, Montana—A Registered Nurse; former Director of Community Health Aides, Blackfeet Community Action Program, Browning, Montana. Miss Pambrun has been instrumental in establishing significant health programs on the Blackfeet Reservation, and has received citations from the American Nursing Association; currently Project Director of the Montana United Indian Association "Wiconi Project" Helena, Montana.

ESTHER G. SCHIFF, Miami Beach, Florida—A practicing attorney and member of the New York and Florida Bars; legal counsel to Mt. Sinai Medical Center of Miami Beach, Florida. Mrs. Schiff was Regional Attorney for the Department of Health, Education, and Welfare's Region II office in New York for many years. She has wide experience in public welfare law and health care matters, directed legal activities in the Medicare and Medicaid programs, and served as counsel to the U.S. Public Health Service Hospital in New York. Mrs. Schiff is also Chairman of the Miami Health Advisory Committee of the American Arbitration Association.

ELLA L. STROTHER, Baltimore, Maryland—A graduate of Hampton Institute Virginia; member of the Boards of Directors of the National Consumers Health Organization and the Provident Metropolitan Baltimore Comprehensive Health Center; Parliamentarian of the former. Mrs. Strother was consumer advocate for NCHO Region III and has wide experience with community groups and has been active in health care matters for a number of years.

MONROE E. TROUT, New Canaan, Connecticut—Physician with a law degree, Vice-President of Winthrop Laboratories Division, Sterling Drug, New York, with extensive experience in medico-legal problems particularly pharmaceutical industry liability problems. Dr. Trout is an adjunct professor of pharmacy, Brooklyn College and President of the American College of Legal Medicine.

CARL E. WASMUTH, Cleveland, Ohio—A Physician/lawyer widely recognized as an authority on medico-legal problems; Chairman, Board of Governors, The Cleveland Clinic Foundation; member of numerous medical and legal professional associations and is the author of several books and many articles on malpractice.

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*Summer Interne.

Advisory Panels

The Commission's four technical advisory panels provided useful information on many critical issues. These individuals gave generously of their time to meet, deliberate, and report the results of their discussions. We are indebted to them for their help and to the contribution they have made to this report.

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Lt. Commander JOHN W. KERCHEVAL II

Veterans Administration
JOHN J. CORCORAN
Dr. J. HERBERT SMITH

*Reassigned during term.

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APPENDIX: Reports, Studies, and Analyses (Separate Volume)

Statement of Formal Determination

Purpose

The Commission will advise the Secretary with respect to the entire range of problems associated with professional liability (malpractice) claims against all categories of health care providers and institutions in both the Federal and private sectors, and will make recommendations as to the legislative, administrative and programmatic actions calculated to ameliorate the problems so identified.

The Commission additionally will advise the Secretary with respect to the sources and availability of basic statistical information about malpractice and malpractice claims, both Federal and non-Federal, and will determine the feasibility, costs, and methodology of establishing a nationwide data gathering capability to enable the continuous monitoring of malpractice claims experience and study of malpractice related problems.

Functions

The Commission will carry out its responsibilities by reviewing and evaluating information and statistics relating to the malpractice phenomenon tendered by professional and industry groups, members of Congress, medicolegal experts, Federal agencies, and the general public. In addition, the Commission will review and evaluate statistical data and other information relating to the malpractice phenomenon obtained by means of a series of studies conducted by the Department, primarily through contracts with non-governmental research organizations, universities, and the like.

To supplement the information obtained in the above manner, the Commission will conduct approximately four public hearings in selected regions of the country to obtain the views, perspectives and suggestions of the general public regarding the malpractice phenonenon and related issues. Testimony taken at these public hearings will provide insights not otherwise obtainable and will bring to the Commission's deliberations the widest possible consumer input.

Utilizing information obtained in the ways described above, the Commission will identify and evaluate the fundamental and contributing causes leading to malpractice claims, the relative importance of each, and their measureable health care, legal, social and economic consequences, including their impact on direct Federal and Federally-supported health care programs.

With respect to the health care system the Commission will focus on the etiology and incidence of malpractice claims from the standpoint of medical causation and will determine the possible relationship thereof to (a) demands for health services and availability of health manpower, (b) inadequacies in the education, training or supervision of health personnel, and (c) the effectiveness of existing medical injury prevention programs and other quality control mechanisms. Related areas of inquiry will include: an evaluation of qualitative changes in treatment modalities directly attributable to the current malpractice environment, and the health care costs associated therewith; an evaluation of the degree to which the current malpractice environment may be impeding medical innovation, experimentation, or the free flow of scientific information between health care professionals; an evaluation of negative qualitative changes in physician/patient, hospital/patient and other similar treatment relationships directly attributable to the current malpractice environment; and an evaluation of the degree to which the current malpractice environment may be adversely affecting the recruitment, geographic distribution, utilization, or retention of professional and auxiliary health manpower.

To the extent possible, the Commission will recommend ways to ameliorate all the negative health system consequences so identified, including those affecting direct Federal and Federally-supported health care programs.

Based on other studies, the Commission will evaluate the role of specific legal doctrines, trial tactics, methods of compensating trial counsel, use of juries, and related legal system concomitants as factors influencing either the commencement or outcome of malpractice litigation. The Commission will also evaluate the equity and effectiveness of existing legal mechanisms for the processing of claims by persons seeking compensation for injuries or maloccurrences arising out of treatment and, to the extent possible, will recommend alternatives thereto calculated to improve the equity and/or effectiveness of such mechanisms. In a related area of inquiry the Commission will evaluate the effectiveness of existing legal and administrative (out-of-court) mechanisms for screening, evaluating, arbitrating and processing malpractice claims, and will recommend improvements in or possible alternatives thereto.

With respect to the role of insurance and the insurance industry, the Commission will evaluate the impact and effectiveness of the professional liability insurance system, including the methods used by insurers to determine rates and the ways rates are approved by State insurance regulators, methods and costs of underwriting and selling group and individual coverage, problems of availability of primary insurance and reinsurance, problems and costs associated with the defense of malpractice claims, and the adequacy of existing insurance industry claims-prevention efforts. To the extent possible, the Commission will recommend ways to reduce costs, speed up the claims handling process, assure the continued availability of insurance coverage, and ways to improve claims prevention efforts.

Finally, the Commission will identify and evaluate the attitudes of the general public with respect to the malpractice phenomenon in general, and specifically: the ways patients learn about alleged errors or maloccurrences in treatment, and their reactions thereto; their familiarity with health care quality control mechanisms and attitudes toward present methods for handling grievances regarding health care costs or substandard treatment; possible social and psychological factors influencing (positively and negatively) the filing of malpractice claims; and the degree of public satisfaction or dissatisfaction with current mechanisms for screening, evaluating and payment of claims seeking compensation for injuries or maloccurrences arising out of treatment. The Commission will, to the extent possible, recommend ways to reduce all the negative influences thus identified.

In addition, the Commission will recommend to the Secretary or his designee the initiation of such other studies and the utilization of such expert consultants as it deems necessary to obtain all information and advice necessary to make meaningful recommendations to the Secretary.

Authority

This Commission is established pursuant to Executive Directive (President's Health Message of February 18, 1971) and in accordance with the method established under Executive Order 11007 of February 26, 1962. Duties invested in the Secretary by law are Secs. 222, 301 and 304 of the Public Health Service Act, 42 U.S.C. 210, 241, and 242(b); Secs. 1875 and 1114(f) of the Social Security Act, 42. U.S.C. 1395(11) and 1314(f); 42 U.S.C. 2001 et seq.; and Reorganization Plan No. 3 of 1966.

Structure

The Commission will be composed of twenty-one members, all from the public sector, representing health care providers and institutions, the legal profession, the insurance industry, and the general public. In addition the Commission, in its discretion may recommend that the Secretary utilize the services of additional advisory panels or committees to assist the Commission in evaluating issues dealing with particular aspects of the Commission's work.

The members of the Commission will be selected by the Secretary and invited to serve for a period not to extend beyond Dec. 31, 1972, unless an extension beyond that time is approved by the Secretary. The Chairman of the Commission will be designated by the Secretary.

How the Commission Functioned

The Commission officially began its work in September of 1971, and for the next 16 months went about the task of studying the malpractice problem in a variety of ways. The Commission did not function as a judge or jury seeking to fix blame for the current state of affairs. Its prime objective was to act as a fact-finding body committed to identifying the critical elements of the malpractice problem and recommending possible solutions thereto.

The principal sources of information which the Commission relied upon in arriving at its findings and recommendations were (1) its series of public hearings, (2) its four advisory panels, (3) the Interdepartmental Committee on Medical Malpractice, (4) an external research program and staff studies, and, of course, (5) its own deliberations and expertise.

Public Hearings

At its organizational meeting the Commission voted to conduct a series of public hearings throughout the country, both to obtain technical information and to learn firsthand the attitudes of the professional and lay public regarding the malpractice problem. Seven hearings were held in all, one each in Los Angeles, Cincinnati, New Orleans, New York, Denver, and two in Washington, D. C. During these hearings, which extended over a period of seven months, a total of 212 public witnesses were heard, and the transcripts of these hearings ran to some 3,568 pages.

Since it was the Commission's desire to hear as fairly as possible all sides of the problem no attempt was made to invite witnesses to the regional public hearings.* Paid newspaper announcements were placed in key newspapers throughout each region (occasionally in foreign languages) to assure the widest possible advance notice of the hearings to the general public. Local Social Security Offices were designated as liaison points for local persons to contact if they wished to testify, and despite the volume of witnesses who responded to the newspaper announcements, the Commission turned no one away.

To accommodate all comers, the hearings sometimes lasted for nearly nine hours on a non-stop basis. All in all, the Commission heard testimony on nearly every aspect of the malpractice problem, with 103 of the witnesses representing health care interests, 16 representing insurance interests, 25 representing legal interests, and 68 witnesses from the general public, most of whom spoke about malpractice problems on an individual level.

All witnesses at the public hearings were cautioned not to mention in public the names of particular health care providers or institutions, and all abided by this rule scrupulously.

The daily press and television media were in frequent attendance at the public hearings and media interest ran high at all times. The hearings were the subject of many television newscasts and were given widespread publicity in the local press.

Advisory Panels

Shortly after the Commission commenced its work, four technical advisory panels were created to give the Commission advice on specific issues. Panels were created on health, legal, insurance, and consumer issues, with appropriate representation from each of those interests. Each advisory panel conducted an average of four day-long meetings in Washington, where they discussed and debated issues prepared for them by Commission subcommittees assigned to each subject area.

The results of each panel meeting were formalized in Technical Advisory Reports which were then communicated to all Commission members for their information. Many of these reports provided new insights on the technical matters considered.

The Commission is indebted to its advisory panels for the thoroughness of their deliberations and their responsiveness to the issues presented to them.

Interdepartmental Committee on Medical Malpractice

A special advisory committee was established by the Secretary in September of 1971 to provide Government agency input to the Commission, and particularly to enable the Commission to obtain relevant statistics and other information on malpractice claims experience in the Federal sector. The Army, Navy, Air Force, Public Health Service, and Veterans Administration operate hospitals and clinics throughout the United States that provide direct health care services to approximately 11 percent of the nation's population.

The Committee, which included representatives from each of the above agencies, in addition to representatives from the Department of Justice and Housing and Urban Development, met five times to exchange ideas and to propose ways of minimizing the medical malpractice problem in the Federal health care system.

Early in its deliberations the members of the Interdepartmental Committee acknowledged information gaps in the area of malpractice claims against the United States, similar to the gaps found to exist in the private sector. As a result, a data-gathering effort was begun, which resulted in an analysis of claims against Federal health care agencies which were concluded in 1972. These are detailed in a separate study contained in the Appendix to this report.

For their work in this important and vital area, we

*All major health, legal, insurance, and consumer organizations were invited to present their views to the Commission at two hearings in Washington, D.C., specially set aside for that purpose.

commend the Department of Health, Education, and Welfare for creating the Interdepartmental Committee and we encourage the Interdepartmental Committee on Medical Malpractice to exchange information with the private sector of the health community; and urge that the Interdepartmental Committee continue its efforts and expand this type of interdepartmental cooperation in the future.

Research

The Commission sponsored a $1.5 million contract research program to quantify as many salient parts of the problem as possible. This effort began with a research plan formulated with the capable assistance of the National Bureau of Standard's Technical Analysis Division, and two of the nation's foremost medico-legal authorities, Don Harper Mills, M.D., J.D., and David Rubsamen, M.D., LL.B., both of California.

Extending over an extremely short period of time, considering the complexity of the subject matter, the research program was premised on a systems analysis of the four basic communities of interest involved in the problem (medical, legal, insurance, and general public). The object was to develop a logical, well organized approach leading to (a) identification and comprehensive understanding of the problems, and (b) identification and analysis of alternative solutions to the problems so identified. To the greatest extent possible, the contract research program was limited to quantitative analyses designed to determine the magnitude of problems, and to measure problem area deficiencies in both relative and absolute terms.

In the foregoing manner nine major projects were developed, along with seven lesser studies, under the contract program. These, along with staff studies dealing with isolated aspects of the malpractice phenomenon, are produced in the Appendix to the Commission's report.

While the Commission does not endorse all the findings, conclusions, and recommendations contained in these various studies—indeed, many were not available for detailed review until the very end of the Commission's life—it nevertheless believes that they will be of interest and value as source materials for those whose job it will be to implement our recommendations.

We wish to express our appreciation to our contractors and their staffs for carrying out their difficult assignments under the extraordinary time constraints imposed upon them.

Commission Deliberations

The Commission faced a formidable task in carrying out the Secretary's charge, set forth earlier, especially in view of the limited time afforded us. While our public hearings occupied the major portion of our first seven months of activity, the balance of our time was spent in intensive two-day and three-day meetings where the fundamental directions and concrete decisions were hammered out. All in all, we met for a total of 21 days in this manner, and on the average, 18 members were in attendance, reflecting the deep interest and serious concern of all Commission members throughout the Commission's life.

The deliberation process was undoubtedly the principal means by which the Commission became educated to the various problems requiring solution, and was also the principal method for arriving at our findings and recommendations. Working papers prepared by the Commission staff assisted materially in the development of discussion on specific issues, and in some instances staff papers contained recommendations which the Commission adopted in their entirety. More often than not, the Commission revised staff recommendations to arrive at a consensus on the point under consideration. Votes were taken on all decision issues, with dissenting votes sometimes being recorded in the transcript.

Following the issuance of Executive Order No. 11671 in June of 1972, the Commission's meetings were all held in public session. Generally, several members of the professional press were in attendance at these sessions, and occasionally a member of the daily press. Information and working papers made available to Commission members were aslo made available to observers upon request, as required under Government information regulations.

The body of this report contains the findings and recommendations which we arrived at in the foregoing manner. No report of this nature could be unanimous, and this one is not. It reflects essentially the consensus reached by the Commission on the salient issues presented, with some Commission members choosing to prepare specific dissenting views. On balance, we think all sides of the problem were fully and fairly analyzed and discussed, considering the extremely short time within which decisions had to be reached.

Summary of Recommendations

Defensive Medicine

The Commission finds that defensive medicine is the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted. p. 15

The Commission recommends that over-utilization of health-care resources by any provider should be aggressively attacked by physician-directed regulatory efforts. Hospital utilization committees should be mandatory in every hospital, and their efficiency should be subject to statistical analysis and review by physician-directed supervisory groups. p. 15

In order to encourage physicians to render the highest possible quality care and to reduce the practice of unwarranted defensive medicine the Commission recommends that medical and osteopathic organizations exert maximum moral suasion over physicians who avoid professional responsibilities on the basis of fear of malpractice liability. p. 15.

Good Samaritans

The Commission finds that there is no factual basis for the commonly-asserted belief that malpractice suits are likely to stem from rendering emergency care at the scene of accidents. p. 16

The Commission recommends that widespread publicity be given to this fact in order to allay the fears of physicians, nurses, and other health-care providers in this regard and to encourage the rendering of aid in non-hospital emergency situations. p. 16

Qualified Immunity

The Commission recommends that the states enact legislation to provide qualified immunity to hospitals and members of hospital rescue teams while they are attempting to resuscitate any person who is in immediate danger of loss of life, provided good faith is exercised. p. 17

The Commission recommends that the states enact legislation designed to provide qualified immunity to physicians and other health-care personnel who respond to emergencies arising from unexpected complications that arise in the course of medical treatment rendered by other physicians or other health-care personnel. p. 17

The Commission recommends that all physicians who regularly practice in hospitals be encouraged, through continuing medical education, to become proficient in cardiac arrest and cardiopulmonary resuscitation techniques. p. 17

Allied Health Personnel

The Commission finds that there does not appear to be any indication that the use of allied health-care personnel, particularly registered nurses and technicians, where properly qualified or supervised, has led to any significant problems of medical malpractice liability or malpractice insurance coverage. Where the use of such allied health-care personnel is medically justified, it has not been shown that malpractice problems have significantly restrained their use. p. 17

Media

The Commission finds that despite isolated instances of emotionalism, bias, and inaccuracy, press, radio and television coverage of medical malpractice cases and problems is, on the whole, straightforward, factual, and balanced. p. 19

Patient Injuries

The Commission finds that patient injuries, real or imagined, are prime factors in the malpractice problem. p. 24

Legal Doctrines

The Commission finds that some courts have applied certain legal doctrines for the purpose of creating or relieving the liability of health professionals. The Commission further finds that such special doctrines, or the application thereof, are no longer justified. p. 31

Informed Consent

The Commission finds that the doctrine of informed consent is subject to abuse when it imposes an unreasonable responsibility upon the physician. p. 29

Res Ipsa Loquitur

The Commission finds that the doctrine of *res ipsa loquitur* in its classical sense performs a useful purpose in common law, but that it should not be applied differently in medical malpractice cases than in other types of tort litigation. p. 29

Application of Legal Doctrines

The Commission recommends that legal doctrines relating to the liability of health professionals should be applied in the same manner as they are applied to all classes of defendants, whether they be favorable or unfavorable to health professional defendants. Such doctrines would include (a) the application of the discovery rule under the statute of limitations; (b) the terms of the statute of limitations; (c) the application of the doctrine of *res ipsa loquitur* to injuries arising in the performance of professional services; (d) the rule allowing liability based on oral guarantee of good results, and (e) the doctrine of informed consent to treatment. p. 31

Restatement of Medical-Legal Principles

The Commission believes the time has come to develop greater logic, consistency, and uniformity in the medical-legal rules and doctrines affecting the delivery of health-care, and therefore recommends that all such medical-legal rules and doctrines be clarified and made uniform in application throughout the United States. In order to achieve this objective, the Commission recommends that a broad-based group, representing all segments of the health-care system, the legal profession, and the general public, be convened to develop the appropriate definitions and guidelines in the nature of a Restatement of the Law of Medical-Legal Principles. p. 31

Contingent Fee

The Commission recommends that courts adopt appropriate rules and that all states enact legislation requiring a uniform graduated scale of contingent fee rates in all medical malpractice litigation. The contingent fee scale should be one in which the fee rate decreases as the recovery amount increases. p. 34

Defense Costs

Realizing that the matter of defense costs is an important element in the cost of malpractice insurance, the Commission recommends that a method of minimizing these costs be studied. p. 35

Legal Aid

The Commission recommends that public legal assistance mechanisms be established, or expanded where they already exist, to assure adequate legal representation to persons with small malpractice claims. p. 35

Medical-Legal Cooperation

The Commission recommends that the professions of law and medicine seek to improve their level of understanding and cooperation, specifically in the area of malpractice litigation to facilitate the handling of claims in the most equitable manner. p. 36

Expert Testimony

The Commission recommends that organized medicine and osteopathy establish an official policy encouraging members of their professions to cooperate fully in medical malpractice actions so that justice will be assured for all parties; and the Commission encourages the establishment of pools from which expert witnesses can be drawn. p. 37

Notice of Intent to File Suit

The Commission recommends that state laws be amended to require that a written notice of intent to file a malpractice suite be given to the potential defendant within a specific time period prior to the running of the statute of limitations. Upon the filing of such notice, the statute of limitations would be automatically extended for a specified period, to enable the parties to negotiate an amicable settlement in good faith. p. 37

Ad Damnum

The Commission recommends that the states enact legislation eliminating inclusion of dollar amounts in *ad damnum* clauses in malpractice suits. p. 38

Insurance Availability

The Commission finds that malpractice insurance is currently available to health-care practitioners under group plans and the market for such insurance is competitive. Malpractice insurance is also available to individual health-care practitioners, although they appear to have more difficulty in locating insurance sources. p. 38

Umbrella and excess coverage are also available both to individuals and under group plans. p. 38

Insurance Contingency Plan

The Commission recommends that the insurance industry and health-care provider groups work together to develop a contingency plan to provide medical malpractice insurance in the event such insurance becomes unavailable through normal market channels. p. 39

Reinsurance

The Commission finds that to the extent that medical malpractice insurance is available in the primary market, it is available in the reinsurance market. p. 39

Insurance for Free Clinics

The Commission recommends that the free clinic movement consider medical malpractice insurance necessary protection for patients and health-care personnel. To assist in remedying this situation, the Commission recommends that governmental authorities consider the overall need for medical malpractice insurance and its cost in evaluating applications for grants to free clinics, not just the need for coverage of the activities covered by the grant. p. 41

Rate Making

The Commission finds that the present methods for establishing malpractice insurance rates, including groupings of physicians and institutions for rating purposes, may not be equitable for all providers or in the best interests of the public. p. 43

Rating Classifications

The Commission finds that health-care providers by encouraging numerous separate specialty rating classifications have contributed to the establishment of a rating classification program which may be inequitable to some practitioners and which under some circumstances may adversely affect the cost and availability of professional liability insurance. p. 43

The Commission recommends that the American Medical Association, American Osteopathic Association, American Nursing Association, American Dental Association and the American Hospital Association meet with the leaders of the insurance industry to study alternative methods of classifying individual practitioners and institutions for rate making purposes; for example: on a group basis to the medical staff of a hospital or to a county society. p. 43

Rating Hospitals

The Commission recommends that serious consideration be given to establishing level premium rates for hospitals within a distinct area based on the number of beds and/or out-patient visits. p. 44

Statistical Reporting

The Commission finds that inadequacies in the collection and analysis of appropriate data have precluded the development of sound actuarial practices and rates, and that state insurance departments are generally inadequately equipped to monitor effectively the rate making process employed in establishing malpractice insurance rates. p. 45

The Commission recommends that the National Association of Insurance Commissioners work with the insurance industry to establish a uniform statistical reporting system for medical malpractice insurance and that data be reported to a single data collection agent who will compile it, validate it and make it available to state insurance regulators, carriers and other interested users. p. 45

Marketing Malpractice Insurance

The Commission recommends that the insurance industry develop improved channels of communication concerning the marketing, economics and quality of medical malpractice insurance so that responsible sources of medical malpractice insurance are more widely known to health-care providers, insurance brokers, and independent insurance agents. p. 45

Insurance Services

The Commission recommends that purchasers of medical malpractice insurance, especially associations and institutions, give due regard to the loss prevention and claims handling capabilities of prospective insurance carriers and that active programs be instituted and encouraged in cooperation with insurance carriers designed to prevent the

occurrence of injury as well as to assist in disposing of meritorious cases as quickly and as fairly as possible. p. 45

The Commission recommends that states require insurers issuing medical malpractice policies to disclose loss prevention and claims settlement practices on request by purchasers and in any sales promotional material distributed to prospective purchasers. p. 45

Medicare

The Commission recommends that Congress and the Secretary of HEW review those portions of Title 18 of the Social Security Act (Medicare) which contain benefit payment restrictions and other limitations that impede patient rapport and, which may tend to increase the number of malpractice claims. The Commission urges re-evaluation of Title 18 so that patient frustrations are reduced to the extent feasible. p. 46

The Commission recommends the launching of an educational and public relations program aimed at Medicare participants in order to increase understanding of the program's statutory limitations and to decrease public dissatisfaction and frustration which may lead to malpractice claims. p. 47

The Commission recognizes the need to measure and evaluate the impact of malpractice claims and litigation on the costs of Medicare and other Federally-supported health-care programs and the Commission therefore recommends that appropriate studies be initiated to achieve that objective. Such analysis should include not only the premiums involved but the cost of handling the claims and the costs to other Federally-sponsored programs that may also be providing benefits to medically injured persons. p. 47

National Health Insurance

The Commission recommends that new third party payment proposals, such as national health insurance, have benefit structures which are easily understood by patients and providers and that the administration of such plans be as simple as possible to avoid, to the extent possible, retroactive denials of claims and other administrative impediments which might exacerbate the patient-provider relationship and create an environment conducive to disputes, claims, and suits. p. 48

Overlapping Benefits

The Commission recommends that an indepth analysis be made to identify the cost of overlapping health insurance benefits and to identify methods of using these resources to assure more complete coverage to all. No new Federal or Federally-funded program should be initiated without taking these factors into considerations, and all existing programs should be reviewed to achieve these objectives. p. 49

Licensure

The Commission finds that the competence of individual providers of health-care affects the overall quality of care. The Commission also finds that most State medical practice acts do not have adequate provisions for disciplining practitioners who have been found incompetent. p. 52

The Commission recommends that all State medical practice acts include specific authority to State licensing bodies to suspend or revoke licenses for professional incompetence. p. 52

Re-Registration of Health-Care Providers

The Commission recommends that the states revise their licensure laws, as appropriate, to enable their licensing boards to require periodic re-registration of physicians, dentists, nurses and other health professionals, based upon proof of participation in approved continuing medical education. p. 53

Expediting Sanctions

The Commission recommends that the States enact legislation which limits the duration of judicial *ex parte* stay orders to the minimum period necessary to hold an adversary hearing in cases of suspension or revocation of the licenses of health professionals by State Boards. The adversary hearing should be given priority on any court docket. p. 54

Rehabilitation of Practitioners

The Commission recommends that State licensing laws emphasize rehabilitation of practitioners who have been found guilty of infractions. p. 54

The Commission recommends that State Boards of medical and osteopathic examiners be authorized to prescribe a range of intermediate disciplinary actions in addition to suspension or revocation of licenses, such as requiring remedial education. p. 54

Nationwide Standards

The Commission recommends that a feasibility study be made regarding the establishment of uniform national procedures for examining and licensing health professionals and the establishment of uniform standards of practice. p. 54

Re-Certification of Physicians

The Commission recommends that specialty boards periodically re-evaluate and recertify physicians they have certified. p. 55

Public Scrutiny

The Commission recommends that all state boards of medical examiners include lay members. p. 55

The Commission recommends that all disciplinary hearings be open to the public. p. 56

Institutional Licensure

The Commission recommends that studies be made to determine the impact on the quality of care of institutional and organizational licensure for allied health personnel (other than registered nurses) as an alternative to individual licensure. p. 56

Staff Privileges

The Commission recommends that the States enact legislation to authorize, with due process, the appropriate committee of a hospital medical staff to suspend, revoke, or curtail the privileges of a physician or hospital staff member for good cause shown. The committee members and the hospital should have qualified immunity from suit for their acts. Notification of such actions should be forwarded to the appropriate State licensing boards. p. 57

Continuing Education

The Commission recommends that continuing education be directed toward known needs and that it be designed around performance criteria. p. 59

The Commission recommends that there be imposed upon the existing system of self-regulated continuing education control mechanisms which will require continuing medical education and evidence of provider proficiency. p. 59

Clinical Pharmacology

The Commission recommends that clinical pharmacology, that is, the teaching of actions, indications, side effects, etcetera of drugs used therapeutically be required as part of an integrated program for teaching the basics of therapeutics to all medical and nursing students and that similar attention be given to the same subjects in post-graduate and continuing medical education curricula. p. 60

Using More Nurses

The Commission recommends that physicians, hospitals, nursing homes and other institutions increase the number of professional nurses giving direct care to patients in the interests of better patient care and of minimizing malpractice suits. p. 60

Clinical Education for Nurses

The Commission recommends that in the interests of better patient care and of minimizing medical malpractice suits, nurses should be required to complete clinical practice courses in the areas of planning patient care, assessment of patient's problems, recording and reporting, clinical nursing procedures, working with other medical personnel, and educating patients in implementation of doctors' orders. p. 60

The Commission recommends that clinical courses which include human anatomy, psychology and human relations be required in the nursing curriculum. p. 61

Injury Prevention

The Commission recommends the development of intensified medical injury prevention programs for every health-care institution in the nation, such programs to be predicated on the following:

1. investigation and analysis of the frequency and causes of the general categories and specific types of adverse incidents causing injuries to patients;

2. development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all persons involved in the providing of patient care in such institutions. p. 61

Quality Control

The Commission recommends that institutional quality control mechanisms of all types be constantly evaluated and, where proven desirable, modified so that the information they generate can be fed into a nationwide information system and into continuing education programs. p. 62

Loss Prevention

The Commission finds that where genuine cooperation and support of insurance company loss-prevention programs can be achieved, a meaningful reduction in patient injuries can also be achieved. p. 63

The Commission finds that loss-prevention activities generally are limited to group plans. For the most part, activities aimed toward the individual practitioner have been minimal. There is a need for intensified loss-prevention efforts on the part of the medical malpractice insurance industry working with health-care providers and the consumer community. p. 63

The Commission recommends that the medical malpractice insurance industry develop sophisticated loss-prevention programs based on both injury and claims prevention techniques. This development will require the active participation of the provider and consumer community. p. 63

The Commission recommends that a portion of the premium dollar for institutional medical malpractice insurance be specifically identified and allocated towards loss-prevention. Health-care providers should implement and monitor the loss-prevention programs developed in cooperation with their insurance carriers. p. 63

The Commission recommends that medical malpractice carriers provide analyses of incidents to institutional health-care providers in order to aid the institutions' injury prevention programs. p. 63

Nationwide Data Collection

The Commission recommends that health-care providers, consumers, attorneys, and the insurance industry form a consortium to collect and report information relating to medical injuries and medical malpractice to a Federal or Federally-sponsored data-gathering service. p. 65

It is further recommended that the Secretary of Health, Education, and Welfare convene representatives of these groups (1) to determine the kind of data needed, and (2) through existing data facilities in HEW, to work with private industry to develop the information. p. 65

Individual Privacy

The Commission recommends that the Congress, by appropriate legislation, confer privacy to the raw data collected for a nationwide medical malpractice data system comparable to the privacy that has already been accorded to data collected by the Social Security Administration and the Internal Revenue Service. p. 65

Federal Assistance

The Commission recommends Federal sponsorship of research and demonstration programs in order to develop the recommended injury prevention programs. The Federal Government should also support the development of a nationwide system for the continuous monitoring and evaluation of medical injury prevention measures, in order to assure the cross-fertilization of new techniques and approaches between and among all categories of health-care providers. p. 65

Human Relations Training

The Commission recommends that all medical, dental, and nursing schools develop and require participation in programs which integrate training in the psychological and psychosocial aspects of patient care with the physical and biological sciences. p. 69

The Commission recommends that all categories of health-care personnel receive training in order to develop attitudes and skills in the interpersonal aspects of patient care. This

training should utilize the most advanced educational technology and should be included in post-graduate and continuing education programs as well as throughout the entire period of undergraduate training. p. 69

The Commission recommends that staff conferences be expanded to include discussion of the ethical, social, and psychological aspects of patient care, and that periodic faculty-student seminars be devoted exclusively to discussion of these matters. p. 69

Improving the Health-Care Environment

The Commission recommends that improvements be made in the physical environment and methods of management of hospitals and other health-care facilities to assure greater attention to the psychological and psychosocial needs of patients. p. 70

Education of the Public

The Commission recommends that special programs be developed to educate the public on health-care subjects about which patient knowledge is deficient, and which may contribute to later malpractice litigation. These subjects should include: health and hygiene (including the origins of disease, function of the body organs, nutrition needs, etc.); how to communicate with health-care personnel; the economics of medical care; the conventions of medical practice (e.g., consultation, referrals, use of surgical assistants, etc.); and the limitations of medical science. p. 70

The Commission recommends continuing programs of research and analysis aimed at increasing knowledge and understanding of patients' psychological and psychosocial needs and that findings of such research be translated into specific action programs aimed at improving the physical design and methods of management of health-care facilities and at improving the training of health-care personnel in the human relations aspects of patient care. p. 71

Patients' Rights

The Commission recommends that hospitals and other health-care facilities adopt and distribute statements of patients' rights in a manner which most effectively communicates these rights to all incoming patients. p. 71

Teaching Hospitals

The Commission recommends that the functions of teaching hospitals be explained to all patients entering such hospitals, and that these functions be emphasized in other forms of consumer education. p. 74

Socio-Economic Distinctions

The Commission recommends that where they exist, distinctions in the treatment of patients in teaching hospitals based on the patient's race or socioeconomic status be eliminated. p. 74

Informed Consent

The Commission finds that there is a generally recognized right of a patient to be told about the danger inherent in proposed medical treatment. That right is consistent with the nature of the doctor-patient relationship and with fundamental fairness. A much greater degree of communication between health-care providers and patients is really good, basic medical practice and should be encouraged. p. 74

The Commission finds that the law relating to the nature of information which the health-care provider must supply to obtain valid consent for treatment is presently in flux. Adoption of uniform standards requiring full disclosure of material risks would eliminate much confusion as to the basis and nature of informed consent. Under such standards, both patient and doctor would gain a clearer understanding of their respective rights and obligations. p. 75

The Commission recommends that a responsible member of the patient's family be given appropriate explanations where the physician is justifiably reluctant to explain such matters directly to the patient because of his concern that the explanation itself is likely to have an adverse effect on the patient. p. 75

Access to Medical Records

The Commission finds that the unavailability of medical records without resort to litigation creates needless expense and increases the incidence of unnecessary malpractice litigation. p. 75

The Commission finds that patients have a right to the information contained in their medical records and recommends that such information be made more easily accessible to patients, and the Commission further recommends that the States enact legislation enabling patients to obtain access to the information contained in their medical records through their legal representatives, public or private, without having to file a suit. p. 77

Alteration of Medical Records

The Commission recommends that the states enact legislation to prohibit modification, alteration, or destruction of medical records with the intent of misleading or misinforming the patient. p. 77

Clinical Research Standards

The Commission recommends that physicians engaged in clinical research consider as minimum standards of ethical conduct the World Medical Association's Declaration of Helsinki and the American Medical Association Guidelines for Clinical Investigation. p. 77

The Commission recommends that where clinical investigation necessarily involves the participation of persons who are not legally competent to give valid consent, extraordinary precautions be established to protect the interest of such persons. p. 77

The Commission recommends that the biomedical research community make every effort to educate its prospective members in the fundamental principles of research ethics. p. 78

Protection of Human Subjects

The Commission recommends that the Department of Health, Education, and Welfare guidelines on medical research involving humans be applied to all persons participating in medical research regardless of the source of funds which support the investigation. p. 79

Insurance for Research Subjects

The Commission recommends that whenever a grant or other funding is provided by the Federal Government for medical research involving human subjects, that the grant include a sum sufficient to provide either insurance or a self-insurance fund in order to provide compensation to any human subject who may be injured in the course of the research. Where the Federal Government itself conducts the research, precisely the same rules should apply, either through the Federal Employees' Compensation Act or other funding. p. 79

The Commission recommends that whenever research involving human subjects is conducted by the private sector, that insurance be provided to protect against mishaps, injury, or illness directly arising out of that research. p. 79

Consumer Involvement

The Commission recommends that the Secretary of Health, Education, and Welfare and the administrators of other Federally supported health-care delivery and medical research and demonstration programs establish and continue consumer involvement activities at the planning, services, supervisory, management, and coordination levels by means of board membership, advocacy and advisory mechanisms. p. 81

The Commission recommends that the same degree of consumer involvement be fostered by all appropriate non-Federal health-care delivery and research programs. p. 81

Grievance Mechanisms

The Commission recommends that all health-care institutions establish a patient grievance mechanism capable of dealing with patient care problems. p. 84

The Commission recommends that, to the extent possible, patient grievance mechanisms be established to deal with patient care problems in non-institutional settings. p. 85

The Commission recommends that the Secretary require, as a condition of receiving Medicaid and Medicare payments, that all health-care institutions establish a patient grievance mechanism capable of dealing with direct patient care problems. p. 84

The Commission recommends the initiation of research programs to determine the best way to utilize patient grievance mechanisms to deal with problems involving patient care,

including all health-care providers: hospitals, nursing homes, HMO's, clinics, and private practitioners, and also all levels of regulation—Federal, State, and professional. p. 85

State Office of Consumer Health Affairs

The Commission recommends that there be established in each State an Office of Consumer Health Affairs. The Commission further recommends that Federal financial assistance be made available to the States to encourage the establishment of such offices at the earliest possible date. p. 86

Claims Handling

The Commission recommends that medical malpractice carriers develop mechansims for improved claims handling. In particular, we recommend attention be given to the detection and analysis of incidents having a claims potential to allow early disposition, and to further experimentation with advance medical payments. p. 90

Screening Panels

The Commission recognizes the value of local efforts to mediate medical malpractice disputes, and therefore recommends continuous experimentation with voluntary mediation devices. The Commission also recommends that persons other than attorneys and members of the profession involved in the disputes be included as members of any mediation board or panel. p. 91

Imposed Arbitration

The Commission recommends more widespread use of imposed arbitration as an alternative mode for resolving small medical malpractice disputes, providing the arbitration mechanisms have the following characteristics and do not preempt contractual arbitration agreements:

1. Arbitration statutes enacted by the States should be designed to give jurisdiction over all parties, plantiffs and defendants, involved in a specific medical malpractice case.
2. State arbitration laws should set a maximum monetary limit for invoking the jurisdiction of the arbitration board, with cases demanding higher amounts being handled through the present jury system.
3. Arbitration panels should include some persons who are neither attorneys nor persons involved in the delivery of health-care services.
4. There should be the right of trial *de novo* subsequent to arbitration in the highest level jury court in the State.
5. The State arbitration statute should provide economic and legal sanctions, in order to discourage subsequent trials *de novo* of questionable merit, (e.g. evidentiary rules, presumptions, taxation of court costs).
6. A fairly detailed synopsis of each arbitration decision should be made and published in order to establish precedents, provide information necessary to evaluate and improve the arbitration system, and provide adequate feedback information to the health-care system.
7. Although the Commission has recommended that the results of formal arbitration proceedings be published, publicity focused on the names of parties involved in disputes should be avoided or minimized. p. 93

Enabling Legislation

The Commission recommends that all States that have not adopted legislation to make binding arbitration awards possible enact such legislation. p. 94

Contractual Arbitration

The Commission finds that the utilization of contractual arbitration as an innovative method of resolving malpractice disputes is an important development that justifies continued experimentation and study prior to universal adoption. p. 96

Freedom of Contract

The Commission recommends that no patient be required, as a condition for receiving service, to sign an agreement requiring him to agree to arbitrate any future dispute arising out of the service. p. 96

Note: This recommendation does not apply to agreements for comprehensive health-care services in which the arbitration agreement may be a part of the overall contract for health-care services.

Lay Representation

The Commission recommends that the panel of arbitrators include representatives from the public other than members of the professions involved in the dispute. p. 96

Public Record

Furthermore, the Commission recommends that the results of contractual arbitration, including the award and the basis of the award, be made a matter of public record for the purposes of study and improvement of quality of care and the avoidance of unnecessary injury to patients. p. 96

Federal Coercion

The Commission is opposed in principle to any form of government activity which would induce or compel a health-care provider or a patient to agree to arbitrate disputes prior to the event which gives rise to the dispute. p. 96

Alternative Compensation Systems

The Commission recommends that the Federal Government fund one or more demonstration projects at the State or local level in order to test and evaluate the feasibility of possible alternative medical injury compensation systems. p. 102

The Commission finds that further study is warranted and essential for better definition of the event for which compensation should be paid and for developing a method of financing whatever new system is recommended. p. 102

State Pilot Programs

The Commission recommends that one or more State governments study and investigate, by all appropriate means, including pilot programs, the feasibility of establishing a patient injury insurance program, similar to workmen's compensation insurance, to provide designated compensation benefits for injuries arising from health-care, whether caused by medical malpractice or not. p. 102

The Commission recommends that the various proposals suggested here be developed, tested and demonstrated through both public and private initiatives, especially those which, if possible, would promptly compensate medically injured patients without regard to a finding of fault. p. 102

Implementation of Recommendations

The Commission recommends the creation of a non-governmental, non-profit organization which would be the nationwide focal point for malpractice research, information, education, and prevention activities. The proposed organization should be broadly based and representative of the public at large, including health-care providers and third party payors, both public and private, the legal profession, insurance industry, and consumers. p. 103

Funding for this entity should come primarily from health, legal, and insurance organizations, as well as from philanthropic foundations and individuals. Federal assistance could come through the research grant mechanism and the sponsorship of conferences and activities necessary to establish the organization. p. 104

Chapter 1

Introduction

The Commission philosophically predicates this report upon western civilization's objective, ethical criteria of the rights and responsibilities inherent in the dignity of man. The Commission urges that laymen and professionals alike respect one another's rights and respond in all situations with integrity.

Never in human history has there been such rapid and thorough-going social and technological change as is occurring today. Customs and concepts that have stood for centuries are being altered or discarded. Change manifests itself throughout the fabric of society, in mores and religious attitudes, in socio-political upheaval and economic struggle, and in battles for human rights.

Nowhere has there been more obvious change than in medical science. Within the span of one human lifetime we have gone from the days of the horse-and-buggy doctor to the modern, thousand-bed medical center with all of its nigh-unbelievable sophistication. Today's physicians routinely save the lives and preserve the health of countless patients to whom the old-time physician could offer only death-bed solace. Technical advances in medicine have made it possible to prevent, cure or ameliorate many diseases and injuries which were considered hopeless in earlier years. Hospitalization for tuberculosis has virtually been eliminated by drug therapy. Death from bilateral kidney failure or destruction has been reduced by kidney transplants and hemodialysis. Previously inoperable cerebral tumors can now be operated upon by cryosurgery. Open heart surgery prolongs the lives of many cardiac patients.

The science of medicine has come so far that many people tend to forget the long way it has yet to go. Cancer and heart disease still kill thousands each year; stroke victims may be partially rehabilitated but not cured; multiple sclerosis is a deadly enigma; and countless patients continue to succumb to infectious disease in spite of all the antibiotics.

Medical advances are not without their price. New drugs, new techniques, and new machinery bring with them new risks, and no degree of professional competence and training can guarantee a successful outcome in every medical case.

Medicine, too, for all its widely-heralded accomplishments, is still more art than science. And because no two human beings are alike, the art of medicine in everyday practice involves countless individual judgments by doctors. There are many variables in every treatment situation which must be considered in making a proper diagnosis and instituting appropriate therapy. Inevitably, the degree of delicacy required for so many medical decisions and procedures, combined with the inherent dangers and uncertainties of modern

medicine, must produce occasional errors or failures in treatment. When these occur, when the patient suffers an adverse result in the course of therapy, with or without negligence on the part of the person rendering that care, then the stage is set for a malpractice action.

To the vast majority of patients, malpractice may seem no problem at all. They receive high quality care and they are satisfied with it. The thought of suing their doctors or hospitals never enters their minds. Most doctors and other health care providers go through their entire professional lives without being sued.[1] Most large hospitals in any given year treat thousands of patients, none of whom sues. Why, then, is the medical malpractice problem serious, much less a "crisis," as some call it?

Certainly, it is a problem to the patient who suffers a complication or other adverse result of treatment, whether he has only a minor injury that is not immediately repaired or whether, at the other extreme, he has been totally and permanently disabled. It is a problem to the doctor who is sued, whether he simply loses some sleep and time worrying over a small nuisance claim or whether, again at the other extreme, he loses a major malpractice suit and suffers severe damage to his emotional state, his finances and his professional career. To these individuals, medical malpractice is an important matter indeed, on a very fundamental, personal level.

If only this small number of patients and providers were affected by medical malpractice, it would be an always worrisome and sometimes tragic matter, but it would not be the national problem that it is. But the fear of being sued permeates the entire health-care community. The consequence is, as testimony before the Commission and its special studies show, that the problem touches almost every facet of our health-care delivery system. Costs, patterns of medical practice and forms of medical treatment, the distribution of health manpower, the relationships between doctors and patients, even confidence in equal justice before the law—all of these and more are affected by the problem.

It was this pervasive nature of the malpractice problem that focused national attention on the subject and prompted President Nixon, in February of 1971, to direct the Secretary of Health, Education, and Welfare to convene a Commission on Medical Malpractice "to undertake an intensive program of research and analysis of the problems associated with malpractice claims against all categories of health care providers and institutions in both the Federal and private sectors." The President's directive, contained in his Health Message to Congress, included the following observation:

> *"The consequences of the malpractice problem are profound. It must be confronted soon and it must be confronted effectively—but that will be no simple matter. For one thing, we need to know far more than we presently do about this complex problem. . . ."*

The establishment of the Commission on Medical Malpractice in August of 1971 was the outgrowth of the Federal Government's interest and concern, not merely with the rising volume of malpractice claims, but with their potential impact on health-care costs, health manpower, and the delivery of health services. Since the Government is the largest single purchaser of health services, this concern is appropriate and lends emphasis to the need for a concerted effort to focus on the problem at the national level.

Historical Perspective

Not too many years ago, a medical malpractice suit was a relatively rare occurrence. Seldom did physicians and other health care providers find themselves the targets of suits by dissatisfied patients. During the 19th Century and the first two or three decades of the 20th, there was essentially no such thing as a malpractice "problem" in the United States. On the whole, sickness was accepted as a usual and expected thing. It was not at all uncommon for a woman to bear a dozen or more children and see only three or four of them grow up. Croup, diphtheria, and scarlet fever swept away the young; accidents crippled the farmer and the

[1] Throughout this Report when the words "physician" or "doctor" are used, the term includes osteopathic physicians and dentists, unless otherwise specified or otherwise made clear by the context. The term "health-care provider" includes all persons and institutions who render health services.

industrial worker; childbirth decimated the ranks of women; and pneumonia was a general threat to all. Concurrently, medicine itself was comparatively limited and adverse results of treatment more often than not were either regarded as the natural outcome of disease or attributed to "the will of God."

The first significant change began in the 1930's. California, then ranking only sixth in population, suddenly surpassed all other states in the number of malpractice suits. Similar jumps were soon noted in Ohio, Texas, Minnesota, and the District of Columbia. Thereafter, the number of malpractice suits continued to grow until World War II when the number of cases temporarily declined.

The tempo of malpractice litigation again began to increase shortly after World War II. In part, this was due to the simple fact that many more people were able to afford, and received, medical care, automatically increasing the exposure to incidents that could lead to suits. At the same time, innovations in medical science increased the complexities of the health care system. Some of the new diagnostic and therapeutic procedures brought with them new risks of injury; as the potency of drugs increased, so did the potential hazards of using them. Few would challenge the value of these advances, but they did tend to produce a concomitant number of adverse results, sometimes resulting in severe disability. Lacking an appreciation of the complexities and hazards of modern medical practice, many patients undervalued the inherent risks and assumed negligent conduct when the final outcome was less than had been expected; thus the number of malpractice claims and suits increased.

Changes in medical technology also brought about changes in the patterns of medical practice. The general practitioner gave way to the specialist and sub-specialist, and the locus of much practice moved from office and home to clinic and hospital. While most of these changes have been beneficial, they have resulted in a gradual shift from treatment of the patient by a single practitioner to treatment by groups or teams and institutions, and to more impersonal care. Few would deny the influence of psychological factors as contributing causes to litigation, and as changes in patterns of practice fostered a less personal physician-patient relationship, the stage was set for greater misunderstanding and disharmony.

The post-World War II era brought still other changes which appear to have influenced the volume of malpractice claims and litigation. There was a dramatic increase in all forms of personal injury litigation, much of it arising out of automobile accidents. There was also a perceptibly rising tendency on the part of the public to seek damage for all sorts of real or imaginary harms. In part, this was attributable to the growing interest in consumer rights and a concomitant trend toward the socialization of compensation for all types of injuries. While the malpractice problem was but part of this general trend, it produced a circular effect; as the number of cases and the sizes of awards grew, so did the interest of the legal profession. There was a significant increase in the skill and proficiency of the legal profession in prosecuting malpractice cases; what was once a field for a few medico-legal specialists became an area of more than passing interest to growing numbers of personal injury lawyers. This development made it easier for a patient who felt aggrieved to find competent legal counsel.

Meanwhile, the press and broadcasting media fostered greater public interest in medicine and particularly in its "miracles", leading the public to develop many unrealistic expectations about medicine's capabilities. Many Americans regard good health as though it were a commodity, something that the doctor can dispense at will. But good health is not a purchasable commodity. It is a matter first of heredity and, above all, a matter of personal responsibility, choice, and self-governance. Unfortunately, the failure to achieve ideal health has caused great disappointment with the results of treatment on the part of some patients and they have turned with greater and greater frequency to the lawsuit as a means of resolving their disappointment.

The Need for a Study

We know that malpractice claims and suits have been increasing in frequency for the past decade and that this has had a decided impact on health care practices and costs, on malpractice insurance availability and costs, on modes of processing

claims through our legal system, and on the attitudes of the public towards the delivery of health care in general. What we have lacked is the factual and quantitative information so necessary to describe the dimensions of the phenomenon and to plan intelligent remedial action. As a Commission, we have been acutely aware of this dearth of hard facts and have made the search for scientifically credible information our overriding objective.

In our deliberations we have been mindful of the many common assertions surrounding this subject and we have attempted to assess the validity of many of them. If we accomplish nothing else, we will have achieved some degree of success if this Report corrects some of the current misconceptions about the magnitude of the problem and the fundamental causes and consequences of malpractice claims and suits. The subject has spawned entirely too much rhetoric and speculation, most of which has impeded the search for viable solutions.

Since problem-solving begins with problem definition, one of our chief tasks has been to define the malpractice "problem" itself, and to identify its constituent elements. In this process we have come to appreciate that there is no uniquely identifiable "malpractice problem," but rather, a complex of problems involving interacting medical, legal, sociological, psychological, and economic factors. To the extent we have been able to do so, we have focused on the interplay between these various elements, and our recommendations reflect our belief that piecemeal, narrow remedies cannot possibly cope effectively with a phenomenon of such complexity.

The creation of a Federal Commission to study the problems of medical malpractice is ample evidence of the importance of the subject to society. We are not dealing with a matter of concern only to the relatively few aggrieved patients and the doctors and hospitals they sue. We are dealing with a problem of national concern that vitally affects the ways in which health care is rendered in this country. The malpractice problem is like a proliferation of cancerous cells which have spread throughout the health-care system. Its consequences, as noted by the President, are indeed profound.

Just as we view the malpractice problem as a complex of problems arising out of the dynamics of our health care, legal, insurance and social systems, so are we convinced that the solution to this problem-complex is dependent upon improvements in each of these systems and sub-systems, and upon the cooperation of the principal participants therein. Certainly, there are no simple solutions, and this Report does not presume to set forth any panaceas. We do believe, however, that our proposals, taken together, can help to ameliorate the problem and to improve the quality of health care of all.

This has been a pioneering effort and a considerable amount of information has been gathered on a subject never before subjected to this level of inquiry. For all of this, we point out that still more needs to be done. It is the Commission's hope that this Report will be both a useful tool for those who will put remedial measures into effect now and a helpful guide to those who must deal with the problems of medical malpractice in the future.

Chapter 2

Magnitude and Impact of the Medical Malpractice Problem

Magnitude of the Problem[1]

There are more than 206 million Americans who are provided medical care by the nation's 279,000 doctors, 96,000 dentists, 649,000 nurses and 2,000,000 other allied health personnel. The following tables give some perspective regarding the utilization and distribution of the medical care provided.

Table 1.—Ratio of Selected Measures of Medical Care to the Population of the United States in 1970 (206,000,000)

	Number	Per 100,000 people
Doctors providing patient care	279,000	135.4
Dentists providing patient care	96,000	46.6
Nurses employed	649,000	315.0
Hospitals	7,000	3.4

Source: Statistical Abstract of the United States, 1972, pp. 68-71.

Table 2.—Utilization of Health Care in the United States in 1970

Medical care:	The average physician treated 3,396 patients in 1970.* The average patient visited a physician 4.6 times in 1970.
Dental care:	The average dentist treated 3,219 patients in 1970. The average patient visited a dentist 1.5 times in 1970.
Hospitalization:	1 out of every 6.5 persons was hospitalized during 1970.

*According to The Profile of Medical Practice 1972, American Medical Association, the average physician had 6,360 contacts with patients. However, this figure includes within-hospital visits, while the patients-treated figure in the table does not include multiple contacts with hospitalized patients.

Source: Statistical Abstract of the United States, 1972, pp. 69-73.

[1]Much of the data that appear in this Chapter and the rest of this report are based upon preliminary results of the Commission's study of medical malpractice claim files closed in 1970 by 26 major malpractice insurers. There may be slight variations between the data which appear here and that which appear in the Appendix, since the Appendix is based on later tabulations and analyses.

Table 2 gives some perspective regarding the potential exposure of health-care providers and patients to medical malpractice claims. The Commission study of medical malpractice claims files closed in 1970 sampled 20% of the files closed by 26 companies. Based upon this survey and a separate survey of more than 50 companies regarding the number of claims opened and closed, it is possible to estimate the number of claim files, incidents, patients and defendants. The figures that are underlined in Table 3 are extrapolated from the other figures in the table which are derived from the studies mentioned above.

Table 3.—1970 Estimates

	Closed claim file survey (@ 90%)	Total claim files closed	Total claim files opened
Total files	15,000	16,000	18,000
Incidents	12,000	12,800	14,500
Defendants	22,000	23,500	26,500
Files—no claims asserted	4,500	4,800	5,400
Files—claims asserted	10,500	11,200	12,600

Based upon the estimated 14,500 claims-producing incidents that were reported in 1970, there is less than one chance in 100,000 of an incident occurring that will give rise to a medical malpractice suit each time a physician or dentist treats a patient. This ratio is based upon the assumption that incidents that give rise to malpractice claims occur purely by chance. However, as noted later, this is not the case. There is a greater chance that malpractice claims will be filed in some parts of the country than in others, that more claims will be filed against certain categories of practitioners, and that more claims will arise out of certain types of procedures.

On an average working day in 1970, the 26 or so major malpractice insurance companies opened approximately 70 medical malpractice claim files,[2] or about 18,000 files for the year. Not all of these files represented malpractice claims made by or on behalf of patients. In fact, based upon comparable data for files closed in 1970, only 70 percent (or about 12,600) of the files represented claims asserted by patients; the remaining 30 percent were files that in all likelihood will be closed without a claim ever being made. Insurance companies opened these pre-claim files solely on the basis of reports by insured doctors and hospitals of adverse medical incidents or threats made by patients.

The Commission's survey of the medical malpractice claim files closed in 1970 was taken from a universe representing approximately 90 percent of the total. Preliminary analysis reveals that the estimated 15,000 claim files closed in 1970 represented 12,000 incidents and patients and 22,000 defendants—doctors, hospitals, nurses, drug companies, equipment manufacturers.

The number of malpractice claims has been increasingly steadily, especially in certain parts of the country as shown in Figure 1.

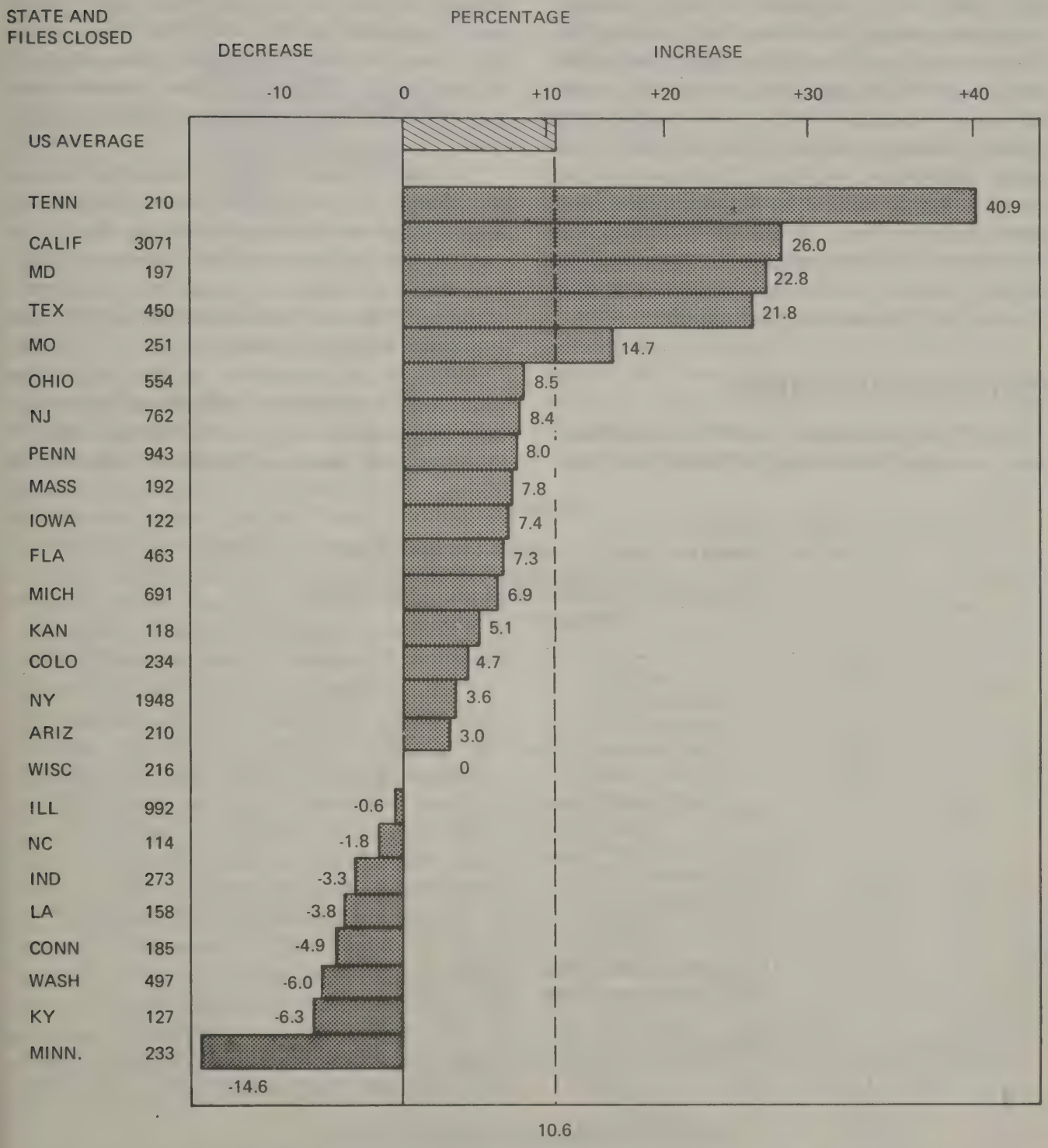
The estimated 10.6 percent increase in claims opened in 1970 over those closed in that year indicates the direction and some of the magnitude of this change. It should be noted that claims closed in 1970 were based on medical incidents that happened as far back as 1960, whereas the files opened in 1970 cover more recent incidents.

Although Tennessee leads the list of states in rate of increase, partly due to its small base number of claims, California is foremost in the volume of change. Only 5 of the 25 states included in the comparison (the rest had fewer than 100 closed claims), showed an increase in rate of claims greater than the average, indicating that most of the increase was concentrated in Maryland, Texas and Missouri in addition to California and Tennessee. Eleven other states showed an increase, but not so much as the average, while Wisconsin stayed the same, and 8 states actually showed a decreased rate, more claims being closed than opened. Minnesota, falling off by 14.6%, had the greatest decline. Many factors including population shifts, changes in insurance carriers, and changes in State law might also be related to the indicated shifts, but these cannot be easily sorted out.

State-to-state differences are also shown by the number of closed claims in the state divided by the

[2] These figures represent "claim files" in insurance company terms, a rather broad classification which includes 1) actual claims asserted by patients or their legal representatives, 2) pre-claims, or as-yet-unasserted claims based upon reports of adverse medical incidents filed by policyholders, and 3) multiple claims, in that some companies open one claim file for every incident—regardless of the number of insureds involved—while others open a separate claim file for every insured, even though arising out of only one incident.

FIGURE 1
PERCENTAGE CHANGES IN CLAIM FILES
OPENED TO CLAIM FILES CLOSED IN 1970
FOR STATES WITH MORE THAN 100 FILES CLOSED



SOURCE: COMMISSION STUDY OF CLAIM FILES OPENED AND CLOSED IN 1970

number of physicians providing patient care, as shown in Figure 2. The gross rate of 6.54 closed claims per 100 practicing physicians somewhat overstates the situation since some claims are made solely against hospitals, dentists, and others, but this gross rate does provide a fairly uniform comparison among the states. Only two of the western states are below the average, whereas the states with the highest rates are New Jersey, California, Montana, Arizona, Washington and Nevada. Although the average rate in some of the smaller states may be influenced by the fact that some carriers do not collect claims data for every state (Delaware may be mixed with some of Pennsylvania, for instance), the state groupings do suggest a western versus eastern bias in the number of claims per 100 practicing physicians.

Proneness to Claims

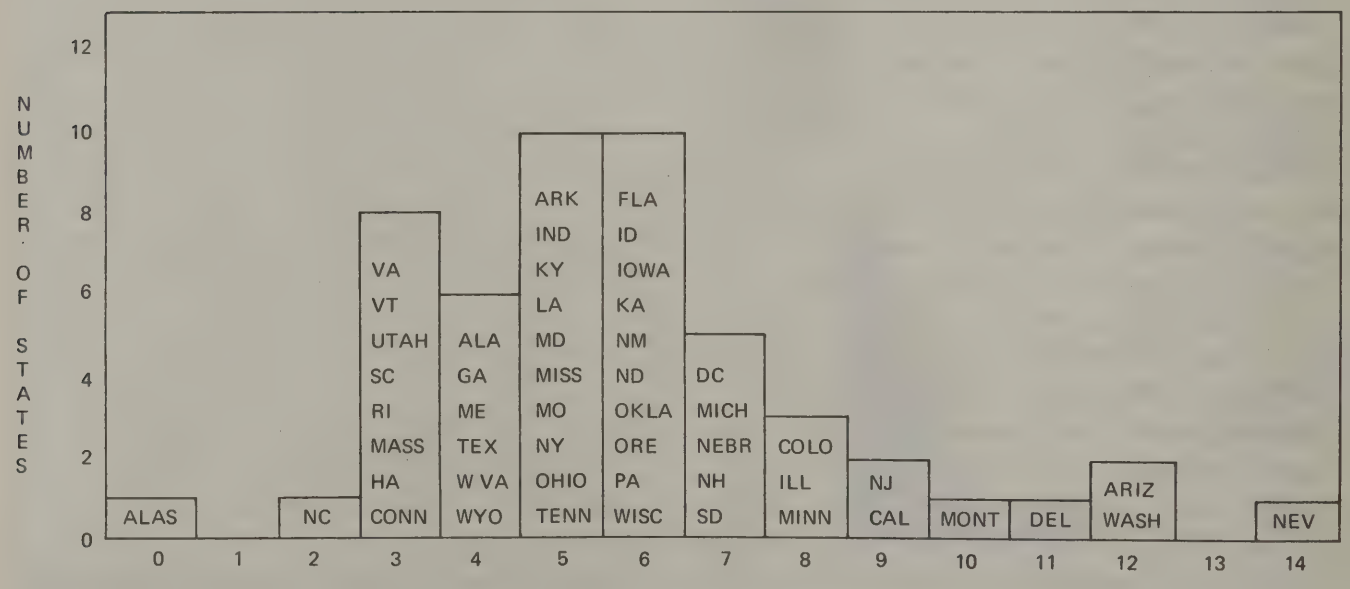
In 1970, approximately 14,500 reported incidents prompted the opening of 18,000 claim files. Based on the 382,000 doctors, dentists and hospitals at risk, one might assume that one out of every 21 health-care providers was the object of a malpractice claim in 1970. However, this is not a true picture of the claims-exposure of the individual provider. As already noted, claims occur more frequently in some states than others. Similarly, more claims are made against some categories of providers than others, and some providers have more than one claim made against them in a given year.

The risks of being sued for malpractice are not shared equally among all practitioners. Orthopedic surgeons and anesthesiologists, for example, by the very nature of the high-risk procedures they undertake, are subject to claims more frequently (Figure 3). Moreover, there are variations in claims experience within specialties.

Although the magnitude of the malpractice problem is often measured with arithmetic averages and average rates, very few of the providers of health care are average. The claims experience of

FIGURE 2

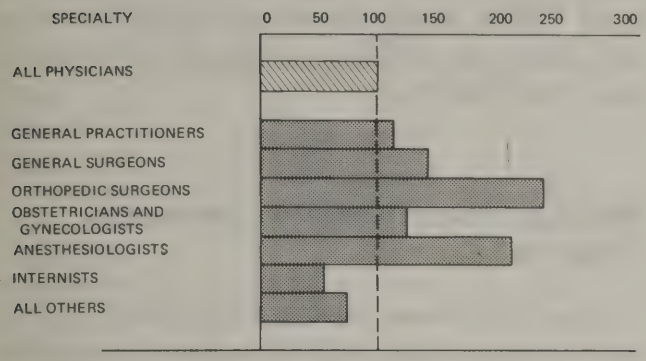
STATE TO STATE DIFFERENCES IN NUMBER
OF CLAIMS CLOSED IN 1970
PER 100 PHYSICIANS PROVIDING PATIENT CARE
AVERAGE U.S. = 6.54



SOURCE: COMMISSION STUDY OF CLAIMS CLOSED IN 1970; DISTRIBUTION OF PHYSICIANS IN THE UNITED STATES, 1970, AMERICAN MEDICAL ASSOCIATION

FIGURE 3

RELATIVE NUMBER OF CLAIMS
BY SPECIALTY
INDEX = 100 (AVERAGE)



SOURCE: COMMISSION STUDY OF CLAIM FILES CLOSED IN 1970

most of them is much better than average, while others give some indication of being malpractice-prone.

A study by the Medical-Chirurgical Society of Maryland[3] indicated that over a 10-year period the number of physicians who would statistically be expected to have more than one claim is 21, but the observed number was 46. Thus, about half of the 46 might be suspected of contributing more than by chance to the number of claims; this leads to the hypothesis that some may be claim-prone.

The claims figures for hospitals[4] are worthy of note in themselves, since 74 percent of all alleged malpractice incidents occur in hospitals. The statistics disclose an entirely different picture than what has generally been assumed. Taken in the aggregate, one might expect the average hospital in the United States to be sued twice in any one year (1.9 claims), but a breakdown of hospital claims experience reveals that some hospitals have much better records than others. If incidents which give rise to malpractice claims occurred randomly, 33 percent of the nation's 7,000 hospitals could be expected to have no claims filed against them during the year. The actual rate, distributed over all sizes of hospitals, was 68 percent. Fifteen percent of the hospitals accounted for more than half of the claims. If this small number could improve their claims experience, the total number of claims could be lowered substantially.

This indication of proneness to suit is not necessarily an indication of the quality of care provided either by particular practitioners or particular institutions. As indicated earlier, suits occur with greater frequency in some states compared with others and for some specialties compared with others. Many factors influence the filing of medical malpractice claims, as discussed in Chapter 4. Here it is sufficient to note that it is possible to identify those areas, practitioners, and institutions which are more likely to be sued. Thus, efforts to reduce the number of suits and the events which give rise to them can be focused where they can be most effective.

What types of treatment give rise to malpractice claims? The Commission's survey revealed that the bulk of the claims arise out of surgical procedures (57.2 percent) as shown in Table 4. As might be expected, more claims alleging injuries in hospitals occur in the operating room (Table 5).

Table 4.—Percentage of Malpractice Claims/Suits by Type of Treatment (1970)

Type of treatment		Percentage
Surgical		57.2
Orthopedic	19.0	
Cardiovascular	1.8	
Gastrointestinal	11.5	
Gynecological	10.3	
Obstetrical	5.1	
Other surgical	9.5	
Medical		20.5
Psychiatric	1.5	
Cardiovascular	1.4	
Other medical	17.6	
Radiological		6.1
Diagnostic	5.2	
Other radiological	.9	
Pathological		1.6
Anatomic	1.1	
Other pathological	.5	
All Other Treatment		14.6
Emergency	5.8	
Vaccinations	1.2	
Other treatment	7.6	
Total		100.0%

Source: Commission Survey of Claim Files Closed in 1970.

[3] *A Survey of Professional Liability Incidence in Maryland,* . Friends Medical Science Research Center, Inc. APPENDIX.

[4] *An Analysis of An American Hospital Association Professional Liability Survey,* William R. Pabst, Jr., APPENDIX.

Table 5.—Location Within Hospital Where Incidents Which Give Rise to Malpractice Claims Occur

Location	Percentage of incidents
Operating room	39
Patient's room	34
Emergency room	12
X-ray room	3
Labor and delivery room	3
Other	9
Total	100

Source: Commission Survey of Claim Files Closed in 1970.

Disposition of Claims

What happens to the claim files opened each year? How many claims prove to be meritorious? How many of them are closed with payment? How much is actually paid to claimants and how long does it take for the claims process to run its course?

Of the 16,000 claim files closed in 1970, 50 percent were closed without the claims resulting in lawsuits, and the claimant or his legal representatives received some payment in about 25 percent of these closed files. The rest of the claims that did not become lawsuits were abandoned or settled without any payment to the claimant.

The other half of the claim files closed by insurance companies in 1970 resulted in lawsuits. Eighty percent of them never went to trial; they were settled by negotiation and mutual agreement, with the claimant receiving some payment 60 percent of the time. The remaining 20 percent of the suits filed were resolved by jury trials with the verdict in favor of the plaintiff 20 percent of the time. In sum, there was payment in approximately 45 percent of all claims, whether or not a lawsuit was filed (Table 6).

Table 6.—Percentage of Medical Malpractice Claims Files Closed at Each Stage in the Process and Percentage Closed With and Without Payment

Stage claim closed	Total	With payment	Without payment
Incident report/pre-claim	28.6	7.4	21.2
Claim/pre-suit	21.7	7.4	14.3
Suit/pre-trial	38.2	24.9	13.3
Trial/pre-verdict	5.0	3.5	1.5
Verdict	6.5	1.6	4.9
Total	100.0%	44.8%	55.2%

Source: Commission Study of Claim Files Closed in 1970.

Meritorious Versus Baseless Claims

Many health-care providers are convinced that the vast majority of malpractice claims asserted by patients are entirely without foundation. In order to test the validity of this assertion, the Commission's study of closed claim files asked malpractice insurers to indicate whether or not each claim file was or was not "legally meritorious in terms of liability." The results indicated that the insurance carriers judged 46 percent of the claims to be meritorious. This percentage is slightly higher than the percentage of all claims paid (45%); however, cross tabulations are not yet available to establish any possible correlation between claims paid and claims judged to be meritorious. Viewed together, the number of claims judged to be meritorious by malpractice insurers and the number in which payment was made to the claimant would seem to indicate that the vast majority of malpractice claims are not "entirely baseless," as often alleged.

Analysis of Claims Paid

The total number of claims paid does not appear to be as important a factor in the overall problem as does the number that give rise to large settlements or awards. These relatively few claims (the 6.1 percent above $40,000) appear to be the ones that most alarm health-care providers. As depicted in Table 7, more than half of the claimants who receive payment get less than $3,000, the other half receive more. Less than one out of every 1,000 claims paid is for $1 million or more, and there are probably not more than seven such payments each year. There is little doubt that the number of large awards or settlements has been increasing dramatically within the recent past.

Table 7.—Distribution of Amounts Paid on Medical Malpractice Claims Closed in 1970

Total settlement costs of incidents, in dollars	Percent of incidents	Cumulative percent of incidents
1-499	21.1	21.1
500-999	16.0	37.1
1,000-1,999	12.3	49.4
2,000-2,999	10.1	59.5
3,000-3,999	3.0	62.5
4,000-4,999	2.7	65.2
5,000-9,999	13.4	78.6
10,000-19,999	10.0	88.6
20,000-39,999	5.3	93.9
40,000-59,999	1.3	95.2
60,000-79,999	1.0	96.2
80,000-99,999	0.8	97.0
100,000 and up	3.0	100.0
	100.0	

Source: Commission Study of Claim Files Closed in 1970.

Table 8.—Percentage of Claim Files Closed in 1970 Relative to Year File Opened

Time, incident to closing	Year of first incident	Percent of cases where known	Cumulative percent of cases where known
Less than 1 year	1970	18.6	18.6
1 year	1969	23.3	41.9
2 years	1968	15.9	57.8
3 years	1967	11.7	69.5
4 years	1966	10.9	80.4
5 years	1965	7.1	87.5
6 years	1964	5.5	93.0
7 years	1963	3.1	96.1
8 years	1962	1.7	97.8
9 years	1961	0.7	98.5
More than 9 years	1960 or earlier	1.5	100.0
		100.0	

Time to Settlement

It takes a long time to close a malpractice claim file. On the average, only half are closed within 18 months after they are opened; ten percent remain open 6½ years after they are opened. Of course, the experience of individual insurers may vary widely. The time from the incident to the closing of the file is composed of many sub-intervals: incident to recognition of injury; recognition of injury to claim filing; filing to suit, etc., all of which appear to be unique to medical malpractice claims.

Profile of Alleged Injuries

Medical injuries vary greatly in the degree and extent of damage to the patient. Of the 12,000 injuries alleged in the survey of claim files closed in 1970, 19% left permanent effects and 18% resulted in death. At the other extreme, 12% of the alleged injuries were primarily psychological. Excluding patients who died, two-thirds of the alleged injuries were temporary in nature.

Most of the malpractice claimants are female (58.0 percent). The patient is usually older than the average of the population. Fifty-three percent of the claimants are over 40, but only one-third of the population is over 40. This probably reflects the fact that older people utilize more medical and hospital treatment than do younger ones. Some 60% of those claiming injury reported having no income. Most of them probably were home-makers who received no salaries, while others reported incomes roughly reflecting those of the general population.

The profile of injured patients is almost identical to the national profile of all patients, suggesting

FIGURE 4

SEVERITY OF INJURIES ALLEGED IN MEDICAL MALPRACTICE CLAIM FILES CLOSED IN 1970

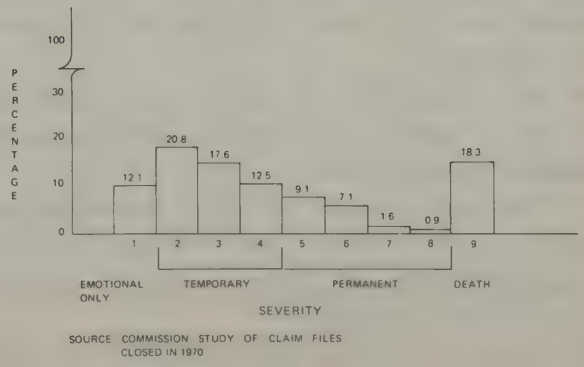


Table 9.—Source of Payment of Health-Care Costs of Persons Filing Medical Malpractice Claims

Source	Percentage
Self	25.9
Health Insurance	47.9
Medicare	11.7
Medicaid	1.2
Workmen's Compensation	7.7
Other	5.6
Total	100.0

Source: Commission Study of Claims Files Closed in 1970.

that no particular group of patients is more likely to assert claims than any other.

The Magnitude In Perspective

- Despite the publicity resulting from a few large malpractice cases, a medical malpractice incident is a relatively rare event; claims are even rarer and jury trials are rarer still.
- In 1970, a malpractice incident was alleged or reported for one out of every 158,000 patient visits to doctors.
- In 1970 a claim was asserted for one out of every 226,000 patient visits to doctors.
- Fewer than one court trial was held for every 10 claims closed in 1970.
- Most doctors have never had a medical malpractice suit filed against them and those who have, have rarely been sued more than once.
- In 1970, 6.5 medical malpractice claim files were opened for every 100 active practitioners.
- A 10-year survey, from 1960 to 1970 of the claims experience of 2,045 physicians in Maryland indicated that 84 percent had not been sued, 14 percent were sued once, and 2 percent were sued more than once.
- Most hospitals, no matter how large, go through an entire year without having a single claim filed against them.
- Sixty-nine percent of 4,113 hospitals surveyed from June 1971 to June 1972 had not had a malpractice claim, 10 percent had one, and 21 percent had two or more.
- Most patients have never suffered a medical injury due to malpractice and fewer still have made a claim alleging malpractice.
- If the average person lives 70 years, he will have, based on 1970 data, approximately 400 contacts as a patient with doctors and dentists. The chances that he will assert a medical malpractice claim are one in 39,500.

Economic Impact of Medical Malpractice

In dollar terms, health is the second largest industry in the United States. In 1971, the total costs of direct health services provided to Americans was $75 billion, roughly 7.4 percent of the Gross National Product (GNP), or $358 per person. Five years ago medical expenditures amounted to just under 6 percent of the GNP or $212 per person. Costs are, of course, a major source of concern to the Federal Government which, under Medicare, Medicaid and other programs, pays 23 percent of the bills for all health-care services provided in the country.

While inflation is the primary cause of rising medical care costs (accounting for 47 percent of the increase) with population growth accounting for another 17 percent, among the other forces accounting for the remaining 36 percent are the costs of malpractice claims and suits. Medical malpractice clearly has increased the cost of medical care. Physicians, dentists, hospitals, and allied health personnel paid between $200 and $350 million for professional liability insurance in 1970.[5] While this figure is not large when compared to the nation's total health-care expenditures of $75 billion (only 4/10 of 1%), the overall impact on the health-care delivery system is significant.

The universal economic impact is obvious. The cost of the provider's insurance is necessarily passed on through his fees or charges and is ultimately paid either by the patient directly or through his health insurance premiums. For ex-

[5]We have two estimates for premium volume. One is based on a survey of the major malpractice insurers, the other is an estimate based upon multiplying average premiums times the number of insureds. The first method provides the lower number, the second method the higher number. Three hundred million dollars is probably a good estimate.

Table 10.—National Price and Index For Hospital Medical Malpractice Coverage, 1960, 1966, 1970, 1972

Year	Premium cost for constant degree of coverage*	Index for medical malpractice insurance (1966 = 100)	Medical services price index
1960	$ 7,051	86.5	92.8
1966	8,153	100.0	100.0
1970	25,546	313.3	116.4
1972	37,610	461.3	n.a.

*The National Daily Average of occupied hospital beds was 217 in 1960, 207 in 1966, and 193 in 1970. Outpatient visits were 188, 226, and 322, respectively. The 1970 figures were used for 1972.

Sources: Insurance Services Office, New York (1960-1972), and Economic Report of the President (1971), p. 249.

ample, approximately 50 cents of the daily cost to every patient going into the hospital is for the hospital's malpractice insurance. In the case of Government-financed health-care programs, the cost is borne by the general public through taxation.

Individual providers are understandably alarmed when one considers that they have had to increase their coverage and that premium rates have also increased tremendously. Premiums for dentists rose 115 percent between 1960 and 1970; those for hospitals, 262.7 percent; those for physicians other than surgeons, 540.8 percent; and those for surgeons, 949.2 percent.

Table 11 illustrates the increase in costs from $110.70 per year in 1960 for physicians in rating category 2, to $767.20 in 1972. More significant, perhaps, is the impact on the physician's income. In 1962 he paid 1/2 of one percent of his gross income for professional liability insurance. By 1970, the impact had more than tripled to 1.8 percent of his gross income. These figures are national averages and they vary widely from state to state. According to the Insurance Services Office rating schedules, class 2 physicians in North Carolina paid 34.6 percent (1/3) of the national average rate, while in California they paid 252.2 percent, more than two and one-half times the national average. Just as every hospitalized patient pays approximately $.50 each day for the hospitals' professional liability insurance so does every patient pay for his physician's professional liability insurance—$.20 to $.50 out of every $10.00 fee,

Table 11.—National Price and Index For Physicians' and Surgeons' Malpractice Insurance, 1960-1972

	Physicians (Class 2)			Surgeons (Class 4)		
Year	Dollar cost	Index (1966 = 100)	Premium as percent of income*	Dollar cost	Index (1966 = 100)	Premium as percent of income**
1960	110.7	71.9	n.a.	229.1	52.3	n.a.
1962	114.9	74.6	0.5	279.1	63.7	n.a.
1964	133.0	86.4	0.5	378.1	86.2	1.2
1966	154.0	100.0	0.6	438.5	100.0	1.2
1968	249.5	162.1	0.8	571.0	130.2	1.4
1970	620.5	403.0	1.8	1,880.9	428.9	4.2
1971	711.5	462.1	n.a.	2,094.0	477.5	n.a.
1972	767.2	498.3	n.a.	2,307.4	526.2	n.a.

*The income figure used is for self-employed general practitioners, Copyright © 1972 by Medical Economics Company, Oradell, New Jersey 07649.

**The income figure used is for self-employed general surgeons; also from *Medical Economics.*

depending upon the physician's specialty and the state in which he practices.

Defensive Medicine

One of the most pervasive impacts of the medical malpractice problem arises out of what is commonly called "defensive medicine." Nearly every physician who testified before the Commission cited the practice of defensive medicine as an example of the harmful effect resulting from the increasing number of malpractice suits.[6] Recent opinion surveys report that between 50 to 70 percent of the physicians polled said they engage in various forms of so-called defensive medicine.

In considering the subject, one of the first problems confronting the Commission was that there was no satisfactory definition of defensive medicine; at least it was apparent there was less than common agreement upon the meaning of the term. Therefore, the Commission needed to propose a working definition of its own and unanimously approved the following:

> *The Commission FINDS that defensive medicine is the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted.*

Positive defensive medicine is the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical-legal liability. (It should be remembered that physicians in all good conscience may disagree over what is medically justified: in a particular case one man's defensive medicine may be—and often is—another's good practice.) *Negative defensive medicine* occurs when a physician does not perform a procedure or conduct a test because of the physician's fear of a later malpractice suit, even though the patient is likely to benefit from the test or procedure in question.

A third form of defensive medicine was also brought to the Commission's attention. There appears to be a reluctance on the part of some physicians to publish in medical journals case reports describing in detail noted adverse effects of diagnostic and therapeutic procedures. The fear is that the material will be picked up and used as evidence in a lawsuit. Determining how widespread this fear may be is as difficult as the analysis of the quantity and quality of defensive medicine itself. But if this fear does exist, it could be a major deterrent to the dissemination of important medical knowledge.

At an early meeting the Commission gave serious consideration to developing a research project which would define, examine, and hopefully reveal the extent to which "defensive medicine" is practiced in the United States. Designing a scientifically-acceptable protocol for such a study proved impossible during the lifetime of our Commission. In seeking to design such a protocol it was the conclusion of many members of the Commission that both the quantity and the cost of defensive medicine may not be measurable. However, the Com believes that defensive medicine, in whatever way defined or extensively practiced, clearly adds to health-care costs.

In the context of the Commission's definition, the practice of defensive medicine, as a means of legal protection for the physician, is an unfortunate diversion from the major goal of physicians in rendering medical care for strictly medical purposes. This is clearly unfortunate for the health-care consumers as well.

Every discussion of defensive medicine overlaps into other problems which are neither directly nor principally related. Questions as to the utilization of x-ray and routine diagnostic procedures, of laboratory tests, and of the number of office visits requested as follow up of medical and surgical conditions may not be related to the present medical liability crisis but, at the same time, they may be. The increased utilization of medical consultation and the frequent and extended hospitalization of patients beyond their apparent medical needs are but a few examples of the social, medical and economic problems confronting both

[6] See Defensive Medicine, Eli P. Bernzweig, APPENDIX.

the health-care consumer and the medical professions as well. Defensive medicine contributes to these problems.

Comments have been made both by Commission members and by witnesses before the Commission that perhaps defensive medicine is a benefit in that more care may be better than less. This point is equally hard to analyze objectively; indeed, analysis may be impossible. However, from the standpoint of the Commission's working definition it appears that any form of defensive medicine whose sole purpose is protection against liability rather than provision of health care does not benefit the patient and discourages the more scientific practice of medicine.

After hearing hours of testimony concerning defensive medicine and comprehensive discussion of the subject in several Commission meetings, and after receiving input from the advisory panels to the Commission, the Commission adopted the following statement:

The Commission FINDS that defensive medicine is practiced, but the extent to which it is practiced is not known. It does increase the cost of medical care, but it is doubtful that this increased cost is measurable.

It is the opinion of this Commission that defensive medicine is a by-product of medical-legal liability problems and not a causative factor in itself.

Any reduction in the practice of defensive medicine can probably be effected only through a reduction of the problems inherent in the nature of medical-legal liability and its root causes.

Overutilization of health-care facilities, particularly unnecessary hospital stays, is often cited as an expecially abusive practice of defensive medicine, one that could have a tremendous impact on the nation's health bills.

The Commission RECOMMENDS that overutilization of health-care resources by any provider should be aggressively attacked by physician-directed regulatory efforts. Hospital utilization committees should be mandatory in every hospital, and their efficiency should be subject to statistical analysis and review by physician-directed supervisory groups.

In order to encourage physicians to render the highest possible quality care, and to reduce the practice of unwarranted defensive medicine, the Commission RECOMMENDS that medical and osteopathic organizations exert maximum moral suasion over physicians who avoid professional responsibilities solely on the basis of fear of malpractice liability.

Broad dissemination of accurate information about liability situations may help to eliminate unnecessary concern that prevents treatment, just as it may help eliminate unnecessary concern that causes overutilization.

Risks of the Good Samaritan

The "Good Samaritan" issue is frequently cited in the popular press as an example of the negative impact of the malpractice environment on the way in which modern medicine is practiced. Doctors, it is commonly asserted, are reluctant to render emergency aid at the scene of an accident. They are fearful that they will be sued for malpractice in the event of any unfortunate outcome, and there is a widespread assumption that many malpractice suits have actually resulted from such circumstances. The fact is that there have been no officially-reported court decisions in which an injured person has sued a physician under such conditions—although it is also true that there is no information on unreported trial-court decisions or out-of-court settlements.[7]

While the fears of physicians about their potential liability for rendering emergency aid are undoubtedly real, they appear to be based on little more than rumor or hearsay, generated and perpetuated in large part by the mass media. The States have reacted to the fears of physicians by enacting legislation designed to encourage the provision of on-the-spot emergency care to acci-

[7] We have just learned of a malpractice suit recently filed in Hawaii in which the Hawaii Good Samaritan Statute has been pleaded as a complete defense by the doctor who was sued. The case had not reached the resolution stage as of this writing.

dent victims by granting some measure of immunity from liability. Many of these statutes apply to nurses as well as physicians. Notwithstanding the passage of such legislation, many health professionals remain convinced that large numbers of their colleagues have been victims of malpractice suits arising out of the rendering of such emergency treatment.

What are the real reasons behind the reluctance of physicians to render emergency care in Good Samaritan situations? In 1963 the Law Department of the American Medical Association conducted a survey to determine whether physicians would be willing to stop and give care to victims of roadside accidents. Almost exactly 50 percent responded that they would not render such care, *whether or not a Good Samaritan statute was in effect.* The existence of such statutes, while undoubtedly a basis for encouraging some physicians to render emergency care, apparently have not had the same effect on others. In any event, these results indicate that there are factors other than legal ones that apparently influence the decision whether or not to render emergency care at the scene of accidents.

As a Commission, we make no specific findings regarding the real causes behind the reluctance of some physicians to provide emergency aid to accident victims. We do believe, however, that the time has come to set the record straight on at least one issue: the legal risks in rendering emergency medical care to accident victims in non-health-care settings are minimal, if not infinitesimal. Health professionals, as well as the general public, should be so informed. However, we believe that Good Samaritan statutes may be of value even if they induce only a few physicians and other health-care providers to render emergency aid.

The Commission FINDS that there is no factual basis for the commonly-asserted belief that malpractice suits are likely to stem from rendering emergency care at the scene of accidents.

The Commission RECOMMENDS that widespread publicity be given to this fact in order to allay the fears of physicians, nurses, and other health-care providers in this regard and to encourage the rendering of aid in non-hospital emergency situations.

Qualified Immunity in Hospital Emergencies[8]

In the hospital, there are certain situations and settings in which cardiac arrest or other life-threatening emergency is always possible, as in the operating room or in the coronary care unit. The hospital is normally prepared for such a possibility and, at least in larger institutions, life-saving personnel and equipment are usually at hand.

However, emergencies can also occur in places or situations where they cannot normally be anticipated: for example, a visitor may have a heart attack in the front lobby. To deal with such possibilities, many hospitals have adopted an emergency procedure which some call "Code Blue". Specific people—doctors, nurses, technicians—are designated as members of a rescue team. They may be working in scattered parts of the hospital, but when an alarm is sent out, they rush to the site to render emergency care. Such teams frequently restore life to "dead" people—dead in the sense that their hearts have stopped.

The Commission believes that the formation of such teams should be encouraged and that health-care personnel should be encouraged to participate in them so that there will be maximum effective response to emergencies. Apparently, though, some hospitals and some doctors are reluctant to participate for fear of increasing the possibility of malpractice suits. If a doctor, for example, working in a distant part of a hospital cannot get to the scene of an emergency in time despite all effort, should he be held liable? Should he be liable if, in the course of emergency treatment, a patient is inadvertently injured? (The Commission was told of a "dead" woman who was restored to life by closed-chest heart massage but whose ribs were broken in the process).

A California statute gives members of rescue teams a qualified immunity in such situations, and the Commission believes that this is good. Such immunity, however, should not extend to persons

[8] See Separate Statement by Richard M. Markus.

who work in places in the hospital in which life-threatening emergencies may be expected to occur, nor to people who are specially qualified to deal with such emergencies and are supposed to be on hand there.

The Commission RECOMMENDS that the states enact legislation to provide for qualified immunity to hospitals and members of hospital rescue teams while they are attempting to resuscitate any person who is in immediate danger of loss of life, provided good faith is exercised.

It was the sense of the Commission that this qualified immunity should apply only in cases where a special rescue team is called to help in an emergency. It is not intended that the immunity should apply to emergencies which occur in hospital intensive care units or operating rooms, where no special rescue team would be summoned.

The Commission also considered the situation in which the fear of liability may make health-care personnel who are not members of special rescue teams reluctant to respond in an emergency. In the course of treatment, an emergency may occur which requires the calling in of additional medical help. The responding health-care personnel (often a consultant-specialist) are unfamiliar with the patient and his medical problems and may be hesitant to step in for fear of being sued for harm to the patient which occurred prior to being summoned.

The Commission does not believe that in such cases the responding individual should be held responsible for any negligence that may have occurred before he arrived on the scene. We believe that all efforts to save life in this way should be encouraged.

The Commission RECOMMENDS that the states enact legislation designed to provide qualified immunity to physicians and other health-care personnel who respond to emergencies arising from unexpected complications that arise in the course of medical treatment rendered by other physicians or other health-care personnel.

In its consideration of emergency situations, the Commission was told that in some instances doctors hesitate to respond because they feel inadequate to deal with the crisis. For example, a dermatologist, a pathologist or a doctor working in administration may well feel himself unqualified to handle a cardiac emergency. Yet such a physician may also be the only one near by when such an emergency occurs. In such cases, the Commission believes the doctor who may be at hand should be prepared to render aid, at least until someone more qualified can take over.

The Commission RECOMMENDS that all physicians who regularly practice in hospitals be encouraged, through continuing medical education, to become proficient in cardiac arrest and cardiopulmonary resuscitation techniques.

Use of Allied Health Personnel

Physicians have always been assisted by allied health-care personnel, most notably nurses. When they have, the physician's professional liability has also included the acts of his employees. Recently, however, there has been considerable debate within the health-care community over the growing trend to use specially-trained allied health personnel to perform tasks which customarily have been done by physicians. A number of physicians have expressed a reluctance to employ these new kinds of allied health personnel,[9] because they are uncertain about the effect it might have on their professional liability insurance premiums and on the chances that they may be sued for the harmful acts of their new assistants. The Commission conducted a study of the problem.[10]

The Commission FINDS that the use by physicians of allied health personnel in physicians' offices and hospitals necessarily involves some greater exposure to legal risks. Since such personnel permit a physician or a hospital to

[9] See *The Malpractice Problem and the Use of Physicians' Assistants,* Eli P. Bernzweig, APPENDIX.

[10] See *The Effect of the Fear of Litigation on the Utilization of Physicians' Assistants,* H. Beth Marcus; Denise Ferguson, APPENDIX.

provide greater numbers of patients with care, the legal risk resulting from the larger volume is obviously increased. The larger number of persons involved in patient care, whose negligence could cause injury, also necessarily increases the legal risk.

The use of allied health-care personnel by physicians, however, also has clear benefits. It relieves the physician from the performance of many routine medical functions, thus enabling him to devote more of his time to more important nondelegable functions. It helps alleviate shortages of physicians in many areas in which such shortages may exist.

Thus far, there does not appear to be any indication that the use of allied health-care personnel, particularly registered nurses and technicians, where properly qualified or supervised, has led to any significant problems of medical malpractice liability or malpractice insurance coverage. Where the use of such allied health-care personnel is medically justified, it has not been shown that malpractice problems have significantly restrained their use.

The impact of medical malpractice on the health-care system is great. It contributes to the rising costs of health care; it causes alterations in the practice and delivery of health care in the form of "defensive medicine," and reluctance to act in emergencies, and in attitudes toward emerging forms of allied health personnel. The Commission also heard testimony that the fear of litigation stifles change and innovation and that it restricts the flow of information regarding adverse medical events. While it was not possible to verify or refute these allegations they are believed by at least some health-care providers.

Impact of Medical Malpractice On the Legal System

Medical malpractice cases are among the most difficult to try. They usually take two to three times longer than other personal injury cases because of the complexity of the requisite expert medical testimony. Thus, although few in total number, they contribute significantly to the congestion and overload of the court system.

The legal system is also under serious attack by many health-care providers because they feel that lay juries are incapable of making findings of fact based upon medical evidence. They feel that jury verdicts and awards are based more on emotion than fact, and fear the spread of large verdicts in 1971 and 1972 from a few states to the nation as a whole. It is difficult, if not impossible, to prove these allegations, but the fact is they are believed, and those who believe them have lost faith in the ability of the legal system to handle medical malpractice cases in a fair manner.

Impact of the Media

The media plays a curious role as a magnifier of the impact of the medical malpractice problem. Many of the reactions of health-care providers and consumers are based on newspaper stories, articles in the medical press, and the electronic media. The appearance of a large headline reporting a malpractice suit against a physician in which astronomical damages are demanded undoubtedly exercises a subtle influence on others who may be considering similar action. Such headlines, however, not only stigmatize the physician who has been sued, but by implication the quality of health care in general.

Notwithstanding the admitted difficulty in assessing the real impact of the media on any social phenomenon in our society, we believed it would be helpful if an analysis were made of the way in which the mass media treats the subject of medical malpractice, and accordingly, a staff study was initiated along these lines.[11] More than 1,200 articles published in both the general and professional press during the 12 months from September, 1971 to August, 1972 were evaluated. So was the press, radio and television coverage of our seven public hearings, which were held in six widely separated cities. Selected writers from the press and broadcast newsmen were also interviewed by the staff to determine their knowledge of and feelings about the subject.

The vast majority of stories dealt with lawsuits.

[11] *The Media and Medical Malpractice,* Michael Byrnes, APPENDIX.

Depth of coverage was found to be very largely dependent upon "human interest" values, such as the involvement of a large amount of money, the sad plight of a severely injured person, or sexual misconduct. There was a relative lack of coverage where lawsuits were won by the defendant. Some feature articles dealt with malpractice generally, mostly as an element in the rising cost of care. Reporters generally said they thought the subject was not of wide interest; they freely admitted to knowing little about it and thought the public knew less.

The Commission FINDS that:

(1) Despite isolated instances of emotionalism, bias and inaccuracy, press, radio and television coverage of medical malpractice cases and problems is, on the whole, straightforward, factual and balanced.

(2) There is a clear and freely-admitted lack of knowledge among members of the working press and electronic media of the complexities associated with the medical malpractice area, and there is an expressed belief among them that an even greater ignorance of the subject exists within their audiences.

(3) Despite the professed belief among many reporters that the malpractice area is too technical for adequate popular treatment, the daily press is nevertheless becoming more sensitive to the significance of the subject and is reflecting this awareness in an increasing number of editorial comments.

(4) There is a growing recognition among professionals, newsmen and the general public, that the mass media, particularly television, by portraying medical "miracles" and failing to properly inform audiences of ever-present limitations, raises expectations that the medical profession can cure everyone.

Impact On People—Physicians and Patients

The public hearings that we conducted in Los Angeles, Cincinnati, New Orleans, Washington, New York and Denver made us acutely aware of the impact of medical malpractice on people, especially physicians and patients. A medical malpractice claim destroys the delicate relationship that exists between a physician and his patient. It is a traumatic event for both. The public exposure of the case is embarrassing: the physician stands accused and personal details about the patient are exposed.

Impact On Patients

Medical malpractice is an injury to a patient caused by a health-care provider's negligence. If the patient can engage an attorney to take his case, and if the attorney is able to prove that the patient was injured by the health-care provider's negligence, then the patient may recover money damages to compensate him for his injury. This process usually takes more than two years from the time of the injury. During that time, the full impact of the injury is borne by the patient. There are few, if any, formal mechanisms to repair the injury or to provide rehabilitation.

The present system works to the serious disadvantage of the patient whose injury due to negligence is of small monetary value. An attorney working on a contingent fee (usually 33-1/3 percent of the amount received) will accept the case of a claimant only when he believes that there is a good chance of winning an amount sufficiently large to compensate him for the time and expense that he will invest.[12] While a $1,000 award might be extremely important to a patient, the $333 fee might not adequately recompense his lawyer for the time needed to handle the case. Clearly, this inability to compensate a slightly injured patient is a flaw in the existing system that requires correction.

There are also gaps in the system for the patient at the opposite pole, the one who has been so seriously injured as to require major physical rehabilitation or life-time care. Only if such patients have been injured due to negligence and are successful in proving this fact are they customarily awarded large lump-sum judgments. When this happens, the payment is considered to be the end of the matter. The Commission is of the opinion that this is not enough, for continued attention

[12] See discussion of the contingent legal fee in Chapter 4.

over a long period of time may be needed. For example, it was suggested that with many such patients, an intensive, sustained effort at rehabilitation, though initially costly, might in the end benefit both society and the individual by making him again a productive person, rather than a lifelong object of care. Presently, however, it is rare that such a patient (whether his injury resulted from malpractice or not) has the sophistication himself, or the assistance he needs, to make that happen.

Impact On Physicians

During our hearings the Commission heard testimony from several physicians who believed they had been unjustly sued for malpractice. In some cases the doctors had clearly suffered serious emotional hurt. At our New York hearing a pediatrician was surprised to find that another witness present in the room was the counsel for the plaintiff who has sued him. Badly upset, he referred to the attorney several times with extreme bitterness, remarking that he would not even watch television that night for fear of seeing the lawyer on the news telecast of the hearing.

An internist told us of a critically ill patient whose treatment required decisions over which he and a colleague had literally agonized. The medical literature reported only two such instances in which other patients had lived. The doctors pulled their patient through, though he suffered a double leg amputation. The patient sued, and through legal proceedings which the doctor-witness believed to have been most unfair, won a judgment. The event had a considerable effect upon both his professional practice and his outlook on life. Asked what a doctor should do, he replied, "Practice the best medicine possible. . . .Retire earlier and seek medical employment which involves less patient contact, which I have done. Practice defensive medicine. *And above all, and this to me is the most important thing, despise what could and should be honored, jurisprudence."*

Even the doctor who has never been sued is ever conscious of the sword of Damocles hanging over his head. As one member of the Commission put it, "As a physician, I live in an aura of fear—fear of suit. Fear contributes to hostility and rarely contributes to constructive action. Medicine has some bad doctors and some bad health-care institutions. We are not proud of them, nor do we defend them, and we are concerned with the correction or elimination of that element. Some do not believe that we have this concern, but believe me it is true. It is my opinion that if this were to be corrected overnight, the professional liability problem would remain. . . .

"The House of Medicine feels belabored. Medical organizations are trying their best to overcome their deficiencies, but in my opinion, malpractice litigation is not the best incentive to improvement. It places medicine in an adversary position, and hostilities too often result. . . .

"It may be hard to believe, but we are a frightened profession. The doctor feels put upon. He feels nude on the corner of the Main Street of life. He often tries to cover himself with pride, and even occasionally arrogance, only to find himself being castrated. He really doesn't want to believe the hostility he feels. . . .The faith of the patient is important to the patient and to his physician. Faith is a power, and the physician continually feels it being eroded by sometimes justified and frequently unjustified attacks."[13]

[13]Statement of George Northup, Page 105. The Commission unanimously voted that Dr. Northup's entire statement be printed in this Report.

Chapter 3

The Fundamental Nature of the Problem

A great many people have devoted serious thought to the malpractice problem without arriving at a consensus on what should be done about it. In part this has been due to the paucity of hard, quantitative data, such as is beginning to emerge from the research done at our behest, but perhaps even more important has been the varying perspectives from which different people view the matter.

One of the Commission's major tasks was to identify the fundamental nature of the malpractice problem itself. We began this task with a few knowns and a great many more unknowns. We knew, for example, that the number and costs of malpractice claims and suits are rising, that malpractice insurance premiums are also rising, and that doctors generally feel threatened by the current legal climate in which claims and suits are being filed. Is this the essence of the malpractice problem?

We were familiar, too, with the frequently-made charge that the malpractice problem is basically attributable to defects in our legal system, notably the alleged expansion of legal doctrines in order to bring about social justice by means of compensating injured persons rather than legal justice for accused physicians. Nor were we oblivious to the common complaint that the lure of the contingent legal fee to personal injury lawyers is the root cause of the malpractice problem, acting as a stimulant to the mounting volume of litigation. How valid are these assertions?

What about negligent treatment itself? Are the vast majority of malpractice claims meritorious from the legal standpoint, as many lawyers contend? Is the essence of the malpractice problem a simple matter of incompetent doctors negligently injuring too many of their patients? Or is it, as many doctors believe, the combination of unfair laws and doctrines working to make them victims of over-expectant, suit-minded patients and unscrupulous, money-hungry lawyers?

Most past discussions of the malpractice question have reflected such limited perspectives; hence, too many proposed "solutions" have been little more than a search for someone to blame. What is needed is not a scapegoat, but rational and objective analysis; and above all else, we must carefully distinguish between *causes* and *results* of the problem. Our attention should focus on the disease itself, and not merely its symptoms.

The Commission recognized the need for systematic analysis of the chain of events from initial causation to ultimate consequences in order to find viable solutions to identified problems. We employed this rationale in all our contract studies, and it is this basic, problem-solving approach which underlies most of our recommendations.

In the material which follows, we set forth an analysis of what we perceive to be the fundamental and contributing causes of the malpractice problem as it exists today. In succeeding chapters we discuss ways to remedy some of these causes, always conscious of the extremely complex and dynamic nature of the problem we are dealing with. We also examine the present system for resolving medical malpractice disputes and suggest some changes and alternatives. Finally, we look at the injured patient and his need for rehabilitation and compensation.

Some Fundamental Distinctions

There are vastly important differences between an *injury* that a patient may suffer in the course of medical or surgical treatment; an injury that is caused by *negligence* (which is malpractice); and a malpractice *claim*, which is an allegation, with or without foundation in fact, that an injury was caused by negligence. Practically all discussion about the medical malpractice phenomenon within the recent past has centered on claims and suits—the fact that they are increasing in number; the fact that they are becoming more costly to settle; the fact that they are driving insurance rates sky high. Malpractice claims and suits are the most visible aspect of the problem, and in that sense may be the most reliable index of the problem's intensity. But claims and suits are simply the more or less formal way in which complaints about adverse results of treatment are expressed.

The genesis of virtually every malpractice claim or suit is a physical or mental injury or other adverse result of treatment sustained by the patient. This does not mean that every malpractice claim or suit is founded on negligent conduct by physicians or other health-care providers. As a matter of fact, the Commission's survey of malpractice claims files closed in the year 1970 shows that most of the alleged injuries were not negligently caused—based upon what is probably the only useful gauge of this fact: whether a settlement or award was made to the injured person.[1]

Nevertheless, the underlying problem begins with some injurious event in the course of treatment, and it is this fact which must be faced squarely if we are to develop any meaningful remedial action. It follows that attention must be directed to the root causes of medical injuries in order to reduce the likelihood of their occurrence as much as possible.

Many physicians believe that there are far more malpractice claims and suits than there are injuries to patients. They see the essence of the problem as a plethora of baseless (nuisance) claims and suits filed by dissatisfied patients. At the other end of the spectrum, many personal injury lawyers believe that there are a large number of injuries to patients which have barely been tapped by legal process. Thus far, there has been little reliable data to support either position. There has also been little scientific effort to analyze the relationships between the volume of medical injuries incurred during medical management, the number due to negligence, the number of malpractice claims which have followed, and the number of such claims which have resulted in compensation to injured patients.

The Commission felt it essential to obtain a better understanding of these relationships and we were assisted greatly by one of our staff consultants, Don Harper Mills, M.D., J.D., who developed the following graphic portrayal of the pertinent relationships.

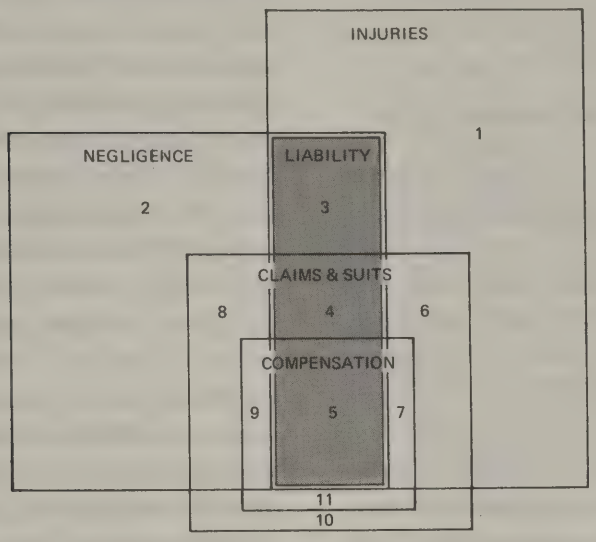
When the malpractice problem is viewed in this manner, it is understandable why there are so many varing hypotheses about its nature and why solutions have not come easily. We believe that a great deal more attention must be devoted in the future to assessing the magnitude and relative size of the injury, claim, and compensation universes. Our pioneering survey of 1970 closed malpractice claims has developed much useful information on claims and compensation, and our two studies dealing with medical injury identification[2] have

[1] 45% of all 1970 closed claims terminated in payment either by way of settlement or verdict.

[2] *Incidence of Iatrogenic Injuries,* Geomet, Inc., APPENDIX; and *A Survey of Medical Injuries Described in Hospital Patient Records,* John Boyden, Jr., APPENDIX.

Figure 1

MEDICAL INJURIES, NEGLIGENT CONDUCT,
AND MEDICAL MALPRACTICE CLAIMS



LEGEND

Zone 1: all physical and mental medical injuries, whether or not caused by negligence.

Zone 2: all instances of negligent conduct by members of the health care team, whether or not such conduct caused injuries.

Zone 3, 4, and 5: (the overlap of zones 1 and 2) all injuries caused by negligence on the part of the health care team. These are the actionable injuries under the current tort system of liability and theoretically, should result in the payment of compensation.

Zones 4 through 11: all malpractice claims and suits filed.

Zones 8 and 9: all claims in which there is negligence but no injury. Claims in this zone are usually made by disgruntled patients who are dissatisfied with the results of treatment or with the manner in which it was provided.

Zones 6 and 7: all claims and suits where there is injury but the injury is unrelated to negligence.

Zones 10 and 11: logically, there might be some claims and suits even in the absence of injury or negligent conduct.

Zones 5, 7, 9, and 11: all claims and suits where compensation has been paid.

Zone 9: all claims and suits where there is negligence but no injury. On rare occasions the conduct of a member of the health care team may be so reprehensible that settlement is made in the absence of any injury to avoid adverse publicity and embarrassment.

Zone 7: all claims and suits in which compensation is paid for injuries which are not caused by negligence. Occasionally, the injury may be so devastating (brain damage or quadripegia) that a suit is compromised and payment is made even in the absence of negligence to avoid the possibility of a larger award by a sympathetic jury.

Zones 7, 9 and 11: all claims and suits paid that, under the present tort system of liability, are theoretically not justifiable for actual compensation.

This chart is not intended to depict the actual size of each category. It is schematic only and must remain so until reliable data to measure them are forthcoming.

Diagram by Don Harper Mills, M.D., J.D.

given us a microcosmic look at the injury universe. Only with larger scale studies, however, will we obtain a better feeling for the size of these universes.

Causes of Medical Injuries

Any discussion of causes must begin with the inescapable fact that modern high-quality medicine carries risks that unavoidably result in some injuries to patients, no matter how much care, skill and judgment is applied. No operation is absolutely safe, and the more advanced ones carry a proportionately high degree of risk. Highly valuable diagnostic procedures, such as angiography and amniocentesis, have their risks and complications.[3] Any drug of real therapeutic value has unpleasant side effects or even dangers for some people. Some drugs do for all, even though their benefits may outweigh their drawbacks. (We were told, for example, of a drug used in the treatment of advanced cancer that causes severe headaches, vomiting and other disagreeable symptoms; a patient who gives his consent to this treatment must literally "take his medicine" in the hope that the long-range gain will outweigh his temporary suffering, just as other patients accept the short-term pain of surgery for the potential long-run benefits.)

There will always be the question of balancing a hoped-for advantage against a risk that must be run. Unhappily, the media emphasis on medicine's dramatic accomplishments has often tended to mask some of the accompanying risks. As one Commission member observed: "With expanded technology and greatly improved quality of care, as well as with elevated patient expectations, we have created a very serious liability for health-care providers who may be claimed to be at fault for failure to reach an ever higher standard. Unfortunately, many of the big cases in malpractice arise from attempts by physicians and institutions to perform the medical 'miracles' that patients expect."

The unfortunate truth is that many patients do not understand this. They see doctors on television who never lose a patient, and they expect their own doctors to be equally infallible. Even the greatest physicians have human frailties; like all of us, they sometimes make mistakes. Even when no mistake is made, there is never certainty about the outcome of medical treatment.

We believe it is important to point out that it is not always possible to determine with precision the causes of medical outcomes, especially medical injuries. Not all injuries are due to negligent conduct and not all injuries are preventable; but many are. While malpractice claims and lawsuits are problems for health-care providers, the health-care system and the legal system, the part of the problem that has the greatest impact on patients is medical injuries, regardless of their causes. The inescapable fact is that most malpractice claims would never be filed if the patient had not been injured in the first place. With the exception of a few psychotics and outright frauds, most people do not file claims for compensation unless they have been hurt.

> *The Commission FINDS that patient injuries, real or imagined, are prime factors in the malpractice problem.*

Numerous studies and surveys have been made which touch upon the number and frequency of medical injuries.[4] However, none of these has been based on a national sampling or done on a scale which would produce credible numbers. The problems inherent in such studies are both definitional (what is "injury"?) and judgmental (how severe is the injury?). The Commission believes that estimating the percentage or number of medical injuries on the basis of present information, whether or not caused by negligent conduct, would be indulging in a "numbers game." In any event, to

[3] The Commission on Professional and Hospital Activities (CPHA), Ann Arbor, Michigan, has been collecting data on complications in medical treatment since 1953.

[4] As long ago as 1955, a study of 1,000 patients put the figure at 5%. (Barr, "*Hazards of Modern Diagnosis and Therapy—The Price We Pay*," 159, *Journal of the American Medical Association, 1452.*) Our own study of two community hospitals found that nearly 8% of the medical charts reviewed showed evidence of injury. *Study of Incidence of Iatrogenic Injuries*, Geomet, Inc., APPENDIX.

do so would merely obfuscate the core problem. Every study produced to date indicates that there are many times more medical injuries than there are claims, and while most of these injuries are not due to negligence, many of them can be prevented, and this is the area which we believe deserves major attention. Of course, we know that no matter how effective the effort to prevent medical injuries may be, some patients will continue to be injured. What happens to these people is as important as the need for the prevention of medical injuries. In Chapter 9 we discuss this equally important issue: compensating persons who sustain injuries arising out of medical treatment.

If injurious or adverse results of treatment are the primary causes of malpractice claims, what are the secondary or contributing causes? In general, they may be classified as indirect influences of an economic, psychological, or sociological nature.

It is generally believed that claims are more likely to arise if the injury or adverse incident is severe and if the patient has no other sources of financial assistance. Thus, the severity of the injury is more apt to be the determinative factor in deciding whether a claim will arise than is the probability that the injury was caused by substandard care or negligence. Other factors which may also stimulate claims, with or without regard to the issue of negligence, include:

- interpersonal problems between provider and patient leading to a breakdown in rapport during the course of therapy;
- frustration with the manner in which specific complaints about ongoing or proposed modes of treatment, including complications, are handled or not handled.
- unrealistic expectations by patients regarding the outcomes of medical treatment, based in part on misinformation and in part on problems of communication between patient and physician (including problems relating to obtaining consent for surgery);
- a growing national trend toward suit-consciousness, health care consumerism, and other sociological stimuli to litigation.

All of the foregoing are discussed in greater detail in subsequent chapters. We do not view any of them as unimportant, but we consider their influence secondary to the injuries which trigger the entire chain of events which constitute the malpractice problem.

Chapter 4

Contributing Causes of the Malpractice Problem

There are a host of factors which significantly influence the initiation and outcome of malpractice claims and suits and thereby contribute to the problem. We turn now to some of these contributing factors, including those related to the legal system, the insurance system, and economic influences. We deal with psychological and sociological contributing factors in Chapter 6 because we believe the human dimension of the malpractice problem warrants comprehensive, separate discussion.

Legal System Influences

There is little doubt that the law, lawyers, and the legal system are integral parts of the malpractice problem. With rare exceptions, the legal system provides the only mechanism by which patients who have suffered injury as a result of medical treatment can obtain redress. In recent years the presumed causes of the growing number of medical malpractice claims have been widely debated. An articulate medical community has often charged that lawyers and the legal system are in large part responsible for this phenomenon. An equally articulate trial bar has responded with the counter charge that the growing number of malpractice claims is due to an increasing awareness on the part of consumers concerning their legal rights to redress for all kinds of personal injuries, and that, if anything, there is a wide disparity between the actual number of compensable injuries to patients and the number of claims which patients file. The Commission accordingly has been aware of the need to assess the impact of the legal system on the malpractice problem in some detail. One of our major studies[1] dealt exclusively with the legal system and our deliberations frequently touched upon the role of lawyers, the efficiency of the legal system and related topics.

A fundamental issue that evoked considerable debate was the influence of legal doctrines on the initiation or outcome of malpractice litigation. In this connection the legal doctrines most often discussed were *res ipsa loquitur*, informed consent to treatment, the discovery rule as applied to statutes of limitations, the locality rule, strict liability, and oral guarantees of good medical results. Each of these legal rules has evolved from

[1] *Legal System Study*, Westat, Inc., APPENDIX.

judicial decisions in actual court cases, as have nearly all the legal rules which affect malpractice litigation under our common law system. Once a new or expanded rule of law is established and reported by an appellate court, it is binding on all lower courts in that state. Frequently, it has a persuasive effect on the courts of other states when they do not have their own legal precedents governing a specific issue that must be decided.

Much Commission debate centered on the expanding nature of various established doctrines, and the lack of uniformity in their application throughout the United States. Consideration was focused on the charge that discriminatory extension or misapplication of certain of these doctrines to matters affecting the delivery of health care placed physicians and other health professionals at a distinct disadvantage in malpractice litigation.

Res Ipsa Loquitur

The doctrine of *res ipsa loquitur*[2] was singled out as the prime example of this form of judicial discrimination. This doctrine is derived from an old English tort case[3] in which an English customs officer walking near a warehouse was hit on the head by several sacks of sugar which had fallen out of the window above. One of the judges remarked, "*Res ipsa loquitur.*" The court reasoned that sacks of sugar do not fall out of second story windows and hit pedestrians unless someone had been negligent in handling them.

It is the application of *res ipsa loquitur* to medical malpractice cases which the Commission specifically debated. Generally, the complaining party in a malpractice case has the burden of proving that the physician was negligent, but certain conditions may give rise to a shifting of that burden. The doctrine of *res ipsa loquitur* is an evidentiary rule that is permitted to be invoked when (1) an injury occurs which is of a type that ordinarily does not occur except for someone's negligence, (2) the conduct or mechanism which caused the injury was within the exclusive control of the person from whom damages are sought, and (3) the complaining party was free of any contributory negligence. Given these circumstances, the law permits an inference of negligence on the part of the physician and liability will accrue unless the physician (to whom the burden is shifted) proves he was not negligent.

The doctrine of *res ipsa loquitur* is of only limited application and is not ordinarily allowed as a substitute for proof where specific acts of negligence are alleged. It has generally been applied in malpractice cases in selected circumstances: the leaving of foreign objects in the patient's body after surgery; burns or other injuries suffered while the patient was under anesthesia; and so forth.

In California, however, *res ipsa* has been judicially extended to cases of rare medical accidents. In essence, the California courts have said that where there is a rare accident and there is some evidence of negligence, this evidence increases the likelihood that the rare accident was negligently caused.[4] Thus, *res ipsa* is permitted on a conditional basis if the jury accepts the circumstantial evidence underlying substandard medical conduct in rare-accident cases.[5]

The Commission, in view of these apparent expansions of *res ipsa,* carefully considered the possible consequences of the doctrine in the malpractice area. Much argument revolved about the contention that *res ipsa* is unfair to the physician in that it puts him in the position of having to prove his freedom from negligence without the plaintiff having to prove that any negligence occurred, as the law customarily requires. In effect, it allows the question of negligence to be put to a jury on the basis of limited circumstantial evidence and without any expert medical testimony showing that the accused physician did actually depart from the accepted standards of care.

On the other hand, it was also pointed out that historically the gradual expansion of *res ipsa* grew out of the difficulty some patients experienced in obtaining expert medical witnesses in malpractice

[2] Latin for "the thing speaks for itself."

[3] *Scott* v. *London & St. Katherine Docks Co.*, Court of Exchequer Chamber, 1865. 3 Hurl. & C. 596, 140 R.R. 627.

[4] *Cavero* v. *Franklin General Benevolent Society*, 36 Cal. 2d 301, 223 P. 2d 471 (1950); *Seneris* v. *Haas*, 45 Cal. 2d 811, 291 P. 2d 915 (1955).

[5] *Clark* v. *Gibbons*, 66 Cal. 2d 399, 426 P. 2d 525 (1967); *Quintal* v. *Laurel Grove Hospital*, 62 Cal. 2d 154, 397 P. 2d 161 (1964).

litigation.[6] Furthermore, recognition was taken of the fact that *res ipsa*, even now, has not been applied in other states as liberally as in California, and indeed is not applicable at all in the majority of jurisdictions. In the Commission's study of legal doctrines, it was reported that *res ipsa loquitur* has been an issue in an increasing percentage of appellate decisions in the past 20 years. It was considered in 13.4% of the cases decided in the period 1961-1971 as compared with only 6.3% of the cases decided prior to 1950. The Commission is concerned that doctrines like *res ipsa loquitur* not be expanded judicially to the point where the liability of health-care providers is based solely on circumstantial evidence of negligence. The trend in this direction is disturbing and, if not checked, could further aggravate the existing problems. We have but one prime concern: fairness both to patients and to health-care providers. In this light, we do not believe legal doctrines should be applied unfairly to health-care providers or, for that matter, to any group in our society.

The Commission FINDS that the doctrine of res ipsa loquitur *in its classical sense performs a useful purpose in common law, but that it should not be applied differently in medical malpractice cases than in other types of tort litigation.*

Informed Consent to Treatment

The Commission also discussed at length the doctrine of informed consent to medical treatment. It is a basic principle in our society that every man has the fundamental right to the physical security and integrity of his body and that this right shall remain inviolate.[7] Thus, the intentional touching of another's person without his authorization is a legal wrong, a battery.

A patient may, of course, freely consent to the commission of an act which otherwise would be tortious. As an illustration, when a person engages a physician to treat him, he impliedly consents to all procedures that form a reasonable and customary part of that treatment. In general, the physician will be protected if he can show that express or implied consent was obtained from one competent in the eyes of the law to give it. In the absence of such consent, liability may be imposed solely because there was a touching of the patient. In legal theory, it is of no consequence that a medical procedure constituting a battery was performed skillfully and improved the patient's health.[8]

Where a patient gives his express consent to a surgical procedure or particular course of therapy, the physician may nevertheless be held liable if the patient can show that he was not adequately informed of the risks and consequences of the operative procedure or course of therapy. In short, the law requires that the consent be an effective or "informed" one, so that the patient can make an intelligent choice from among the various courses of possible treatment, or to refuse treatment altogether.

Recent judicial decisions in the area of informed consent have imposed an affirmative duty of disclosure upon physicians, whether or not the patient inquires as to specific risks.[9] The Commission notes that the number of cases in which the doctrine of informed consent has been asserted is not large, but further notes that the number is steadily increasing. Moreover, there is some evidence that courts are beginning to apply the doctrine unevenly in order to hold a physician liable when the patient's injury is severe but he lacks sufficient evidence to prove the physician was negligent. It is this injustice which we seek to remedy.

The Commission FINDS that the doctrine of informed consent is subject to abuse when it imposes an unreasonable responsibility upon the physician.

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[6] See Louisell and Williams, *Medical Malpractice,* Matthew Bender and Co., New York, Sec. 14.02, p. 421. We have noted elsewhere that the problem of obtaining medical experts to testify in malpractice litigation has substantially diminished.

[7] Both the common law and the first amendment to the Constitution afford protection of the individual's right to determine what shall be done with his own body. As noted by Mr. Justice Brandeis in *Olmstead* v. *United States,* 277 U.S. 438, 478 (1928); "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred the right to be let alone—the most comprehensive of rights and the right most valued by civilized man."

[8] In some of these instances, the courts will allow punitive damages, particularly where no consent was obtained or the consent was fraudulently obtained.

[9] Two recent landmark decisions upholding this requirement are *Cobbs* v. *Grant,* 104 Cal. Rptr. 505 (1972), and *Canterbury* v. *Spence,* 464 F. 2d 772 (1972). Both are discussed, along with other informed consent cases, by Don Harper Mills, M.D., J.D., in the January, 1973 issue of *Physicians Legal Brief.*

While *res ipsa loquitur* and informed consent were singled out as doctrines which appear to have been unevenly applied to health-care providers by the courts in some states, the Commission discussed briefly several other legal doctrines which, in some instances, have been applied unevenly and unfairly in medical malpractice cases.

Discovery Rule

All states have enacted laws establishing time limits for filing various classes of lawsuits commonly referred to as statutes of limitations. Statutes of limitations reflect society's interest in having litigation instituted with dispatch in order to afford justice to all concerned parties. The rationale is that one who has been wronged should not be permitted to bring a suit many years after the event which gave rise to the suit. To do so would be unfair to a potential defendant, particularly since, with the passage of time, memories tend to fade, witnesses die, and essential records are lost.

In personal injury litigation, the statutory period (which varies from state to state) begins to run from the time the alleged negligent act occurred. In malpractice cases, however, the patient may not know immediately that he has been injured by a negligent act. For example, some time may elapse before he discovers that his abdominal pains are caused by a surgical sponge not removed during surgery. Therefore, the courts generally hold that the statute does not begin to run until the patient knew, or in the exercise of reasonable care should have discovered, that a negligent act occurred. Some courts have limited the application of the discovery rule to "foreign body" cases, but others have expanded it to include various negligent acts, as well as the fraudulent concealment of injury by a treating physician.

The gradual expansion of the discovery rule to an increasing number of treatment-injury situations may have an adverse effect on other aspects of the malpractice problem, particularly in the area of establishing rates for malpractice insurance. The rate-determination process is dependent upon knowing with some degree of certainty the total potential losses for a policy year, and any extension of the statutory period makes rate-setting that much more difficult.

Oral Guarantees of Good Results

It has long been held that a physician is not a guarantor of good results. His legal obligation is to exercise due care and skill in the treatment of his patient. With increasing frequency, patients have been suing for injuries arising out of medical treatment under a contract theory of law alleging an oral guarantee of successful outcome of treatment. These suits are usually brought by patients who, because they have delayed bringing suit, have been barred by the statute of limitations in negligence actions. (The statute invariably runs longer in contract actions.) In these cases, since the gist of the action is breach of an oral contract, the plaintiff does not have to prove the physician was negligent in order to prevail.

Where an oral guarantee of good results is actually made and proved, the courts have permitted recovery of damages on the basis of breach of contract. In some instances, however, courts are unfairly allowing stale malpractice cases to be pursued under a contract theory solely to permit damages to be awarded to injured patients. While those cases are few in number, the Commission is concerned that they do not become a precedent that would expand unduly the area of professional liability.

Strict Liability

Recent court decisions have greatly expanded the liability of blood banks, and this has had a decided impact on the delivery of health care. The courts have historically regarded the provision of blood as a medical service, but beginning in 1966, a series of decisions began to hold blood banks liable for injuries to patients based on a theory of implied warranty or strict liability for the sale of blood as a "product." Since that time, nearly all the states have enacted remedial legislation to remove such liability, but a few have not.

The Commission recognizes the vital importance of blood banking to our medical-care system and sees possible harm resulting from attempts to impose strict liability on blood banks.

Unquestionably, the trend in the law in some instances has been towards the imposition of greater liability on health-care providers. The Commission is concerned that this trend may be extended unreasonably and unfairly in the future

and believes that this is bound to have a deleterious effect on the delivery of health care.

The Commission FINDS that some courts have applied certain legal doctrines for the purpose of creating or relieving the liability of health professionals. The Commission further FINDS that such special doctrines, or the application thereof, are no longer justified.

The Commission RECOMMENDS that legal doctrines relating to the liability of health professionals should be applied in the same manner as they are applied to all classes of defendants, whether they be favorable or unfavorable to health professional defendants. Such doctrines would include (a) the application of the discovery rule under the statute of limitations; (b) the terms of the statute of limitations; (c) the application of the doctrine of *res ipsa loquitur* to injuries arising in the performance of professional services; (d) the rule allowing liability based on oral guarantee of good results, and (e) the doctrine of informed consent to treatment.

The Goal Is Fairness

The foregoing findings and recommendations reflect the Commission's concern that the legal doctrines applicable to medical malpractice litigation be applied with fairness and uniformity. There was lengthy debate as to how this might be achieved, and we were by no means unanimous in our views. Some Commission members urged the immediate enactment of remedial legislation at the state level. Others believed such an approach to be premature, particularly in view of the confusion presently exhibited by many segments of the health and legal communities regarding the true meaning and application of the legal doctrines in question. Ultimately, we chose to recommend the creation of a special mechanism for developing such guidelines, being careful to specify the nature of its task and its composition.

The Commission recognizes the growing concern of health professionals, the legal profession, and the general public resulting from a rapidly evolving, non-uniform body of law affecting the delivery of health care. Continued development of this body of law without some semblance of logic, consistency, and uniformity is bound to increase uncertainty in the delivery of health care by physicians and other health professionals, and further exacerbate the present malpractice situation.

The Commission believes the time has come to develop such logic, consistency, and uniformity in the medical-legal rules and doctrines affecting the delivery of health care, and therefore RECOMMENDS that all such medical-legal rules and doctrines be clarified and made uniform in application throughout the United States. In order to achieve this objective, the Commission RECOMMENDS that a broad-based group, representing all segments of the health care system, the legal profession, and the general public, be convened to develop the appropriate definitions and guidelines in the nature of a Restatement of the Law of Medical-Legal Principles.

In carrying out this responsibility, the group so convened shall, at the very least, focus on the following legal rules or doctrines which have created a significant amount of confusion and uncertainty:

- **(a) informed consent**
- **(b) *res ipsa loquitur***
- **(c) locality rule**
- **(d) evidentiary rules relating to the qualification of expert witnesses**
- **(e) discovery rule, as applied to statutes of limitations**
- **(f) oral guarantees of results of treatment**
- **(g) definition of death and other medical-legal questions involved in the treatment of dying patients.**

The Dying Patient

While the fundamental issue of legal definition of death was considered at length,[10] the Commission believes that collateral areas of equal concern

[10]The Commission believes that the question of the legal definition of death is of such importance that the definition should be enacted into law only by the Congress of the United States.

are the medical, legal, and ethical problems involved in the handling of dying patients in general. Who should be authorized to declare a person dead? What about patients in nursing homes, where only a nurse may be in attendance? When should heroic measures in the treatment of patients *in extremis* be terminated, and who should have the authority to make the key decisions? All of these matters deserve special consideration in view of their potential impact on the malpractice problem, but their social, ethical and moral implications reach far beyond that, and must be confronted by society as a whole.

The Contingent Legal Fee

No subject in the entire field of medical malpractice has evoked more bitter feelings between physicians and lawyers than the contingent legal fee system under which most malpractice suits are pursued. Many doctors are convinced that the contingent fee system is the very root of today's malpractice problem, and any number of them have proposed its outright abolition as the most effective way to solve the problem. What is particularly difficult for the physician to understand is why his fees for services to beneficiaries of government programs should be regulated and limited to those which are "usual and customary," while the fees of attorneys go unregulated. That the latter assertion is not entirely accurate[11] —as discussed later in this Chapter—is of little solace to the doctor who firmly believes that the contingent fee prompts overzealous attorneys (1) to accept non-meritorious cases, and (2) to magnify the nature of their clients' injuries in order to win high awards from sympathetic juries.

The contingent fee arrangement provides a means by which a claimant can obtain legal counsel for little or no charge if he loses his case. If he wins, he pays his lawyer some fraction of the recovery amount, usually between one-third and 40 percent, but occasionally as high as 50 percent. Sometimes, it is a sliding percentage based on the stage of proceedings at the time of settlement (i.e., pretrial, trial, post trial, appeal).

The Commission FINDS that virtually all plaintiff attorneys use a contingent fee arrangement in medical malpractice cases. The most commonly used contingent fee rate is 33 1/3% of the recovery. Some attorneys use a sliding scale of fee rates depending on the stage of the claim at the time of the case's final disposition.

Effect of the Contingent Fee System

The Commission, in its public hearings, heard physician after physician testify to the effect that the contingent legal fee is a potent incentive for lawyers to pursue claims of doubtful merit and to seek irresponsibly-high judgments. The Commission's study of the legal system, which included a special economic analysis of the contingent fee, did not generally support this common belief, although the Commission members were divided concerning the completeness of the study data on this issue.

The contingent fee system is prohibited in Great Britain, but the British Legal Aid Scheme, enacted in 1950, has made it possible for a large part of the British public, otherwise financially unable to do so, to bring damage suits, including malpractice actions, against doctors and hospitals.[12] While the contingent fee is rarely used in Canada, it is now legally permissible in six of Canada's twelve provinces.[13] The number of malpractice claims is much smaller in both countries (though rising in Great Britain); but differences in their social, legal, and health-care systems and ours make discussion of the comparative effect of the contingent legal fee essentially irrelevant.[14]

The Commission believes that most physicians generally place undue emphasis on the influence of the contingent fee system upon malpractice litigation, and that only harm will result from perpetuation of the common beliefs about its role in

[11] The fees of attorneys handling Federal Tort Claims Act cases against the United States Government have been limited by statute to 25% of the amount recovered in the event the case goes to trial, and 20% of the amount recovered without trial. 28 U.S.C. 2678.

[12] See *Malpractice in Great Britain*, Philip Addison, APPENDIX.

[13] Quebec, New Brunswick, Manitoba, Alberta, Saskatchewan, and British Columbia.

[14] See *A Comparative Analysis of Medical Malpractice in Canada and the United States*, Rebecca Welch, APPENDIX.

the overall problem. Our study data showed that the contingent fee system tends to discourage the acceptance of legally meritorious malpractice cases involving minor injury and relatively small potential recovery, and we view this as a wholly undesirable and unfair result of the system. However, most individuals are also unable to afford legal services in malpractice cases on a fixed fee basis. The net result is the same in both instances: recovery for injury denied.

The Commission FINDS that the contingent fee arrangement discourages the acceptance of meritorious low-recovery cases. The Commission further FINDS that on a fee-for-service basis, potential clients would be similarly discouraged from pursuing these same meritorious low-recovery cases, since the average citizen cannot financially support the required lawyer's services.

Is the Contingent Fee Equitable?

The Commission's study of the contingent legal fee produced some interesting data on the comparative equitability of the fees earned by attorneys handling malpractice cases. In order to evaluate the common assertion that "the contingent legal fee system allows plaintiff lawyers to earn excessive fees," data were collected on hours actually spent on malpractice cases by plaintiff lawyers and the fees earned by those lawyers.[15] From this information an hourly fee for plaintiff lawyers was computed and compared with the average hourly fee charged by malpractice defense lawyers in order to see if plaintiff-lawyer fees were unreasonably large. The data revealed that the average hourly fee for plaintiff lawyers came to $63, compared to an average of $50 for defense lawyers. Although these figures indicate that a differential exists, the difference is not large enough to warrant the conclusion that plaintiff lawyers are earning unconscionably large fees in malpractice cases, when compared to the fees charged by their legal counterparts in malpractice cases.

The Commission FINDS that by analytically reducing average plaintiff lawyers' contingent fees to an hourly basis for comparison purposes, there does not appear to be any gross discrepancy between the resultant rates charged by the plaintiff bar and those charged by the defense bar in medical malpractice cases.

A Lot of Work For Nothing

Every plaintiff's attorney is aware, as he listens to a potential client tell his story of alleged malpractice, that his fee is contingent upon winning. Whatever the percentage the attorney may charge, he not only gets nothing if the case is lost, but also must pay all his overhead costs out of his own pocket.

In the Commission's legal system study an analysis was made of plaintiff-lawyer hours spent on lost cases in order to determine whether only trivial effort was expended or whether significant amounts of lawyer time were spent on lost cases. In addition, the economic worth of uncompensated effort was estimated in order to identify what sort of costs claimants might be faced with were it not for the contingent fee system. The study results showed that the average number of plaintiff-lawyer hours spent on zero recovery litigated cases is 440 hours per case.

The Commission FINDS that when, under a contingent fee arrangement, a plaintiff attorney loses a case he will have invested a considerable amount of uncompensated time on that case.

How Much Money Are Lawyers Making?

As noted elsewhere in this report, the median recovery in all malpractice cases concluded in 1970, based on the Commission's Closed Claim Survey, amounted to $3,000. Less than 1% of all the cases closed were for amounts in excess of $100,000. We think the occasional large verdict or settlement has tended to give the impression that *most* malpractice cases are settled for large amounts, and that the attorneys' fees are correspondingly great. Just as stories of large malpractice awards magnify and distort the fears of

[15] The computation included no-recovery cases as well as recovery cases.

health-care providers, they undoubtedly also affect the expectations and judgments of some attorneys who are motivated to pursue the "pot of gold at the end of the rainbow" in cases of questionable merit. This probably occurs most often where the severity of the patient's injury is great, but where there is little or no evidence of physician negligence.

The relatively few attorneys who specialize in malpractice litigation undoubtedly do better than their colleagues who only occasionally handle such cases. By and large, however, the survey data show that half of the attorneys who win a malpractice case on a one-third contingent fee basis earn less than $1,000 for their work, the other half earn more.

What About the Injured Patient?

Both in our public hearings and in our deliberations, the Commission took note of the plight of injured patients whose net recoveries, after payment of hospital and medical bills and attorneys' fees, often were pitifully low. One witness in Los Angeles told us: "I had a serious back injury, and was out of work for two years. I made a $22,000 settlement, and after that settlement I realized $3,000. The attorneys got the balance of the profits and split it with the doctors." We heard other witnesses testify similarly, and while we are not in a position to evaluate the credibility of these witnesses on the amounts they actually recovered, their combined testimony on this issue was compelling.

The Commission is unanimous in the view that society's prime concern must always be the injured patient. His first need is prompt and effective remedial care. He often needs replacement of lost income for his support and that of his dependents, and he may need long-term rehabilitation. These needs are just as great whether his injury was a totally unavoidable consequence of the progress of his disease, or of the necessary treatment, or whether it was due to negligence on the part of the health-care provider.

Elsewhere in this report we take up the matter of exploring new types of compensation systems to help persons who sustain injuries arising out of medical treatment with or without regard to negligence. For the moment, we are concerned with patients whose injuries are in fact due to negligence in treatment and who must receive appropriate compensation for those injuries. A patient who is permanently and severely injured requires a substantial financial return if he is to sustain himself adequately for the rest of his life. The evidence presented to the Commission indicates that often this is not the case.

We recognize the potential harm of the contingent legal fee system in wiping out a substantial proportion of an injured person's recovery. This we cannot sanction, and we do not believe responsible members of the plantiffs' bar are in disagreement with our position. It was brought to our attention that in several states contingent fee arrangements are now subject to regulation by court rule. For example, the New Jersey Supreme Court, in January of 1972, adopted a rule requiring the attorney to advise his client of his right to retain him on a fee-for-service basis before a contingent fee arrangement can be entered into. More importantly, under the rule in question a sliding scale contingent fee system was adopted calling for lawyers' charges not in excess of the following:

(1) 50% on the first $1,000 recovered;
(2) 40% on the next $2,000 recovered;
(3) 33-1/3% on the next $47,000 recovered;
(4) 20% on the next $50,000 recovered;
(5) 10% on any amount recovered over $100,000.

The same court rule states that the permissible fee must be computed on the net sum recovered after deducting disbursements in connection with the prosecution of the claim. It also requires that copies of every contingent fee arrangement be furnished to the client and be filed with the court.

The Commission notes that contingent fees have been regulated by court rule in New York and elsewhere, and while we do not give our unqualified approval to all of these particular arrangements, it is our firm belief that greater regulation of the contingent fee along the foregoing lines is necessary.

The Commission RECOMMENDS that courts adopt appropriate rules and that all states enact

legislation requiring a uniform graduated scale of contingent fee rates in all medical malpractice litigation. The contingent fee scale should be one in which the fee rate decreases as the recovery amount increases.

Defense Costs Are Part of the Problem

In our discussion of the contingent legal fee, the matter of legal fees charged by defense counsel also received attention. It was pointed out that a significant part of the malpractice problem relates to the costs of processing malpractice claims through the system—and defense counsel fees are a major portion of these costs. In the final analysis, the public pays for these costs, since they are reflected in higher malpractice premiums which health-care providers inevitably pass along to the public in higher fees and per-diem charges.

Admittedly, only preliminary analysis has been made of the percentage of total claims-handling costs which are attributable to defense counsel fees, but even these tentative figures reveal the need for a closer look into this aspect of the problem.

Realizing that the matter of defense costs is an important element in the cost of malpractice insurance, the Commission RECOMMENDS that a method of minimizing these costs be studied.

We make no specific recommendation regarding who should undertake such a study, but recognize that it might be a joint effort between the health-care providers and the insurance industry.

Legal Aid For Injured Persons

We have noted that the present contingent fee system works to the disadvantage of the negligently-injured patient whose potential for recovery is too low to offer an incentive to the plaintiff lawyer. In our public hearings we heard of a number of instances in which legal representation was denied on that basis. In New Orleans, a witness who had suffered a foot drop following a vaginal hysterectomy consulted a local lawyer for advice. He told her that she would have to advance $300 in order to start the case, and that additional costs amounting to approximately $3,000 would have to be advanced in order to obtain the necessary out-of-state medical expert witnesses. When informed by the attorney that $10,000 was the most her case was worth, the witness abandoned the thought of suing: "We would have been gambling, and I'm not a gambler."

The Commission believes that legal aid must be provided to injured patients whose cases, though small, appear to be meritorious. We take cognizance of the recent development of various forms of public legal assistance programs throughout the country, and we heartily endorse this development. The National Legal Services Center, created in July of 1972, will provide impetus for the intiation of many legal services programs at the consumer level. The recent passage of California Senate Bill No. 777, authorizing the formation of nonprofit, legal assistance corporations, is another step which we find salutary and worthy of emulating. The need for legal assistance in minor injury malpractice cases is a need which we believe must be met.

The Commission RECOMMENDS that public legal assistance mechanisms be established or expanded where they already exist to assure adequate legal representation to persons with small malpractice claims.

How Will the Public Know?

The rapid development of legal assistance programs with varying characteristics will undoubtedly create some confusion on the part of the public, and the Commission is particularly concerned that the public be adequately and carefully informed about the availability of such legal assistance for persons with small malpractice claims. Such information can come from various responsible sources, including the American Bar Association, the Association of Trial Lawyers of America, the National Legal Services Center, insurance carriers sponsoring legal insurance programs, and health insurers like Blue Cross, whose New Jersey affiliate recently established a separate corporation to administer a legal insurance program.

One way in which aggrieved patients could obtain authoritative advice and guidance in this

respect would be through the proposed State Offices of Consumer Health Affairs which we recommend in Chapter 6, and would be added justification for the immediate development of these consumer-oriented agencies at the state level.

Medical-Legal Cooperation

As significant to the malpractice phenomenon as any of the specific "legal doctrine" conflicts is an underlying core of antagonism that exists between law and medicine—not the natural, although unfortunate, antipathy that inevitably develops between a physician-defendant and a plaintiff's attorney—but the more generalized hostility that can be characterized as interprofessional.

There have been many attempts to fathom the root causes of medico-legal conflict and misunderstanding, and these analyses often point to fundamental differences in ways of thinking. The ways in which physicians and lawyers are educated and trained differ markedly. The law curriculum is a continuous socratic dialogue, while the medical curriculum is largely didactic and authoritative. Controversy and questioning is the foundation of the lawyer's training preparatory to entry into our adversary legal system. The physician, on the other hand, is unaccustomed to challenge and notorious contest—he has been trained to elicit answers through careful, scientific inquiry.

Added to this fundamental disparity is the environment in which each profession lives and works. Just as the operating room is foreign territory to the lawyer, so is the courtroom foreign territory to the physician. Even the professional language of each group acts as a barrier to easy communication.

We believe that cooperation between the two professions is much to be desired. The distrust that currently exists impedes constructive efforts to solve the malpractice problem and militates against the public interest.

Recognition of the need for better understanding and cooperation has led medical and legal groups in different parts of the country to move in this direction. Interprofessional meetings, grievance committees, and other cooperative efforts are being made, although not yet on the scale which would be necessary for significant achievement. The Commission encourages greater collaboration between the two professions.

The Commission RECOMMENDS that the professions of law and medicine seek to improve their level of understanding and cooperation, specifically in the area of malpractice litigation, to facilitate the handling of claims in the most equitable manner.

The Commission identified several other legal system concomitants which, when viewed separately, exert a relatively minor influence on the malpractice problem but assume significance when considered as a whole. We believe that remedial action in dealing with these items should be relatively simple to carry out.

Availability of Expert Witnesses

With few exceptions, it is necessary in a malpractice action for a plaintiff to produce one or more physicians in court to give expert testimony as to the applicable standard of care and the extent to which the defendant physician departed therefrom. This need to obtain expert testimony has given rise to the complaint that doctors rarely, and then only reluctantly, testify against each other. Without such testimony, aggrieved patients cannot prove, or have difficulty in proving, the negligence which has resulted in their injuries.

The Commission, in its consideration of this area, was limited by the fact that little data has ever been collected either to substantiate or disprove the general charge. Although aware that some courts have referred to the so-called "conspiracy of silence" in judicial opinions, the Commission nevertheless believes that such a state of affairs, if it did indeed exist, is much less prevalent now. In any event, there are a number of plausible reasons why physicians might well be reluctant to testify in malpractice cases:

1. The reluctance to suffer loss of time and income from practice that may be involved in a court appearance;

2. The inability to provide care to patients while away in court;

3. The fear and resentment of physicians regarding cross-examination under the adversary legal system;

4. The natural reluctance to injure friends and fellow craftsmen, coupled with the feeling that "there but for the grace of God go I"; and

5. The common belief that the most malpractice claims are without sound basis.[16]

Any or all of these factors may make physicians—individually, and without regard to any so-called conspiracy—reluctant to testify.

The waning importance of the locality rule in malpractice actions,[17] the increasing acceptance of national standards rather than local standards of care, as well as a more cooperative and conscientious response from individual physicians and medical societies, have all combined to make expert testimony more generally available today. The Commission's recommendation on the subject of expert testimony is predicated upon this belief, but we further believe that the health professions should make efforts to encourage the continuing and increased availability of medical witnesses in malpractice cases.

The Commission RECOMMENDS that organized medicine and osteopathy establish an official policy encouraging members of their professions to cooperate fully in medical malpractice actions so that justice will be assured for all parties; and the Commission encourages the establishment of pools from which expert witnesses can be drawn.

Notice of Intent to File Suit

Health-care providers frequently complain of a lack of notice to a physician and his insurance carrier when a malpractice suit is in the making. Apparently, it is not uncommon for a provider first to become aware of a patient's dissatisfaction with his services when he is served with a summons in a malpractice action. Not infrequently, such a summons is served only a few days before the expiration of the statute of limitations. This, in turn, means that considerable time has elapsed since the occurrence of the alleged malpractice, that the physician-defendant's recollection of the event needs immediate and sometimes difficult up-dating, and that there is no possibility of any discussion or settlement prior to suit since the suit has already been initiated.

The Commission believes that this procedure, which precludes pre-suit negotiations and possibly early resolution of the disputes, can be best dealt with by a requirement that notice be given to providers before the filing of an action. Greater equity could thus be achieved, especially if such notice is required to be given within a specific time prior to the running of the statute of limitations. Most importantly, notice prior to the initiation of a suit would facilitate negotiation without any suit necessarily being filed at all. For the physician, such notice can give forewarning and possible resolution without court intervention in meritorious cases. For the patient, such notice can produce prompt settlement, when warranted, without the cost and delay of court trials. Thus, such notice may result in a reduction of the number of malpractice suits brought.

The Commission RECOMMENDS that state laws be amended to require that a written notice of intent to file a malpractice suit be given to the potential defendant within a specific time period prior to the running of the statute of limitations. Upon the filing of such notice, the statute of limitations would be automatically extended for a specified period, to enable the parties to negotiate an amicable settlement in good faith.

Ad Damnum

The Commission considered the prevailing practice of naming specific dollar amounts in the pleading of malpractice actions (the *ad damnum* clause). Except in Pennsylvania and a few other states, where the rule is otherwise,[18] plaintiffs are

[16] Louisell and Williams, *Medical Malpractice*, Matthew Bender and Co., New York, Sec. 14.03, p. 421.

[17] The courts are increasingly holding that medical standards of care should not be limited to those practicing within the same locality as the defendant, but should reflect the standards applicable in medically-similar localities.

[18] In Pennsylvania, under Rule 1044 (b), *Pennsylvania Rules of Civil Procedure*, the plaintiff in any pleading demanding unliquidated damages, merely sets forth whether the amount demanded is in excess of, or not in excess of, $10,000.

required to name specific dollar amounts in the damages they are seeking in lawsuits. These amounts usually bear little relationship to the sums actually expected or eventually obtained.[19]

It is the opinion of the Commission that the astronomical amounts of damages set forth in malpractice complaints by attorneys are an unnecessary source of friction between the legal and medical professions. These large demands attract sensational newspaper coverage, impose needless anxiety and often unfounded notoriety upon defendant physicians, create a feeling of unfair persecution in the medical world and are of no special benefit to the plaintiff-patients.

Accordingly, the Commission can see no merit, but does see probable harm, in perpetuating this practice.

The Commission RECOMMENDS that the states enact laws eliminating inclusion of dollar amounts in *ad damnum* clauses in medical malpractice suits.

Malpractice Insurance Problems

Medical Malpractice insurance is a necessity for today's health-care providers, but it has become a costly necessity. Rising malpractice insurance costs have been a major source of concern for health-care providers, and may thus be viewed as a significant aspect of the entire problem.

Availability of malpractice insurance is another aspect of the problem. Few physicians would dare to practice without adequate insurance coverage. If a doctor were to practice without insurance, he would endanger all his personal assets every time he treated a patient.

Professional liability insurance plays a dual role in the malpractice problem. It indemnifies health-care providers, thereby protecting their assets against major losses, and it provides the major source of compensation for most patients who are injured due to a provider's negligence.

The Commission FINDS that continued availability of adequate medical malpractice insurance for health-care providers is an absolute necessity, both for the protection of the providers and the general public.

Availability of Insurance

Until recently, only a few insurance companies were significantly engaged in marketing medical malpractice coverage. The number of potential insureds was relatively small, being limited to the number of practicing health-care providers. This, plus the sharp increases in the number of claims and the size of awards which occurred during the 1960's, and the difficulty of predicting future losses, were discouraging to companies selling malpractice insurance and to those who might have considered entering the market.

Recently, there has been renewed interest in the field caused by at least three factors: the prevailing level of premium rates is regarded as adequate; an increased awareness among providers of the steps that can be taken to avoid unwarranted claims has made carriers more willing to offer coverage; and health-care providers have begun to shop around for competitive sources of coverage, thereby inducing new carriers to enter the field.

At the present time, some insurance companies are actively soliciting malpractice business. Although the economics of providing this type of insurance have prevented development of industry-wide competition, a health-care provider usually can find several companies willing to provide the needed coverage.

The Commission FINDS that malpractice insurance is currently available to health-care practitioners under group plans and the market for such insurance is competitive. Malpractice insurance is also available to individual health-care practitioners, although they appear to have more difficulty in locating insurance sources.

Umbrella and excess coverage are also available both to individuals and under group plans.[20]

[19] An analysis of 2,784 liability claims brought against members of the California Hospital Association between 1969-1972 showed that the damages asked for were 53 times greater than the damages eventually receovered.

[20] Umbrella coverage is for all types of liability, personal, auto, professional, etc. Excess coverage is for liability greater than the basic policy.

Availability of Reinsurance

Reinsurance is the sharing of policy liabilities with another carrier. The act of reinsurance is "insuring again." Reinsurance is not well known because such secondary insuring does not involve the original insured (the physician or hospital) in any way; it is a contract between the insurer and the reinsurer. Nevertheless, reinsurance occupies a very important part of the process of spreading risk within the whole insurance industry. It is a specialized activity, and in comparison to the total number of insurance companies, there are very few carriers actively engaged in reinsurance. It has been alleged that malpractice reinsurance is difficult or even impossible to obtain and that as a result, malpractice insurance has been restricted or made unavailable. This allegation has led to proposals that the Federal Government provide malpractice reinsurance.

A study of the insurance market initiated by the Commission[21] found that the need for medical malpractice reinsurance varies according to the size of the primary carrier. Some carriers are so large they have no interest in buying malpractice reinsurance. Smaller carriers which use reinsurance are thereby enabled to compete with the larger ones. The smaller the carrier, the more likely the need for reinsurance, especially when high limits of liability are offered. As already pointed out, medical malpractice insurance is customarily written in two policies for reasons quite unconnected with the availability of reinsurance.

The Commission FINDS that to the extent that medical malpractice insurance is available in the primary market, it is also available in the reinsurance market.

Stability of the Market

As recently as 1970, physicians in Hawaii, Utah, Oregon and Nevada found themselves in the midst of a malpractice insurance crisis. Overnight, they were either without coverage or were faced with the possibility of being without it. Fortunately, circumstances have improved, and we find that malpractice insurance is now generally available, both on an individual and group basis. The Commission was assured that the chances of a similar insurance crisis occurring again are slim. We hope so.

However, we are particularly concerned that large numbers of physicians never again find themselves in danger of being without malpractice coverage. Although the industry believes that such crises will not occur in the future, the Commission urges that, as a safety measure, the industry and health-care providers develop contingency plans.

The Commission RECOMMENDS that the insurance industry and health-care provider groups work together to develop a contingency plan to provide medical malpractice insurance in the event such insurance becomes unavailable through normal market channels.

Sudden Cancellation

However, the picture is not an entirely bright one. For example, some practitioners have not been, and are not being, given adequate notice of carriers' intentions not to renew policies. Such a provider may find himself in the difficult position of having only a short time to find a new source of insurance after the arrival of his cancellation notice and before the lapse of his policy. The Commission was informed that one of the benefits of some group plans is that an individual member cannot be arbitrarily terminated without a fair hearing on the reasons for termination.

In addition, the industry generally has not done an adequate job of informing physicians, brokers, and agents of the availability of coverage for individuals. This contrasts with the industry's active efforts to market group plans and make their benefits widely known.

The Commission FINDS that many health-care providers currently do not receive adequate advance notice of cancellation that would enable them to obtain coverage from another source without loss of continuous coverage.

The insurance industry generally has not communicated to health-care providers, insur-

[21] *The Malpractice Insurance Market,* National Planning Association, APPENDIX.

ance agents or brokers the availability of its medical malpractice insurance sold individually. Conversely, the industry actively markets malpractice insurance through group plans.

This is also true for nurses. While the Commission does not believe there is a widespread insurance availability problem with respect to nurses at this time (nurses presently can purchase individual coverage of $100,000-$300,000 for $10.30 a year), approximately two-thirds of all nurses do not have malpractice insurance. Many hospitals include their nurses and other personnel as named insureds under their hospital policies. However, this is not a universal practice, and hospital employees should verify the practice for their particular hospital. In any event, coverage afforded under a hospital's policy would not afford protection to a nurse while engaged in private-duty nursing or while rendering care in other non-hospital situations.

Free Clinics and Malpractice Insurance

The free clinic movement began in this country in the 1960's with a few health-care providers who donated care, primarily to young, white, middle-class people who were living outside conventional society. There are now approximately 300 such clinics, excluding government-run facilities. Today, free clinics are providing health care to thousands of Americans and have become a recognized part of our health-care delivery system.

The larger, better organized clinics do have some form of malpractice insurance, but smaller clinics generally do not. Some do not purchase coverage, because they mistakenly believe they do not need it, since the care they provide is free. Others realize that malpractice insurance is necessary, but do not have the funds to purchase it.

The National Free Clinic Council feels strongly that malpractice premiums should be lower for free clinics because of their good claims experience. There have been some accident claims (i.e., slips and falls), but initial inquiry has not revealed any malpractice claims against these clinics. At present, premiums range from $200 to more than $1,000 a year, depending on such factors as the number of patient visits and the size of the staff.

The Commission was told that in most cases free clinics can purchase insurance under the special classification for "charitable clinics." It is believed that rates will be adjusted as more and more free clinics purchase insurance and statistics on risk develop.

To the clinics, the primary problem brought about by the lack of coverage has been the resulting difficulty in attracting qualified medical staff. Two-thirds of the physicians presently donating care in free clinics are not covered by insurance. Some are interns, residents or physicians who are covered under their hospital policies, but not while doing outside work. Others are retired physicians who work only a few hours a week and do not have any individual coverage.

The Commission is concerned about the lack of malpractice insurance coverage in this area. If the number of clinics continues to grow, and the problem of obtaining adequate insurance is not alleviated, more and more health-care providers and patients will be unprotected.

A mechanism is already available to help some clinics purchase insurance. The Federal Government, under its grant programs, allows a free clinic to use some grant money to pay for that portion of the malpractice premium related to the activities for which the grant was made. For example, if 30% of a clinic's effort goes into a federally-funded narcotics treatment program, the federal grant will allow payment of 30% of the clinic's malpractice insurance premium. However, approximately one-third of the existing clinics have declined to participate in federal grant programs.

It is true that the present federal approach is of some benefit. However, if a clinic is unable to raise the other 70% of the premium, the effort is useless, since insurance companies do not sell 30% coverage.

The Commission FINDS that the free clinic movement is serving an increasing number of persons, and that the number of patients receiving care from such organizations which do not have medical malpractice coverage is also likely to increase.

Therefore, the Commission RECOMMENDS that the free clinic movement consider medical malpractice insurance necessary protection for patients and health-care personnel.

To assist in remedying this situation, the Commission RECOMMENDS that governmental authorities consider the overall need for medical malpractice insurance and its costs in evaluating applications for grants to free clinics, not just the need for coverage of the activities covered by the grant.

Rates and Ratemaking

The dramatic increases in medical malpractice insurance premiums within the past five years have been a major source of irritation to physicians and other health-care providers.

The actuarial principles by which insurance premium rates are developed are mysterious and difficult to understand for most people outside of the insurance industry. Because of this, the insurance purchaser is apt to believe that insurance companies are charging higher premiums than are necessary.

The basic objective of any insurance company is to sell insurance at a rate which is competitive and which will result in a profit for the company. In order to do this, companies employ actuaries to predict future losses that must be paid from present premiums.

The following table illustrates the cost factors that are taken into consideration in developing medical malpractice premium rates. The two columns of figures indicate the percentages of the premium allotted for each cost factor. The Insurance Services Office (ISO) is an independent rating organization used by member insurance companies. The "insurance companies surveyed" in Table 1 refers to companies surveyed by the contractor who prepared an economic analysis of the medical malpractice insurance market for the Commission.[22]

Actuarial Issues

Actuarial principles are similar for any line of insurance. The simple objective is to develop appropriate rates for the term during which these rates will apply. These rates must produce a sufficient premium volume to (1) cover the losses that will occur during the period, (2) cover the administrative expenses of running the business, and (3) provide a small margin for the unknown contingencies, which may become a profit if not used.

While the objective is simple, achieving it in the malpractice area is difficult for three reasons. First, the medical malpractice insurance market is relatively small. The premium volume for physicians and surgeons professional liability insurance does not exceed 2.5 percent of the total property-liability insurance premium volume. Thus, the base upon which actuarial calculations must be made is relatively small. Second, the dramatic changes which occurred in the last ten years in terms of the number of claims and their average cost have deprived the rate maker of his basic ingredients for ratemaking—frequency and average claim cost.

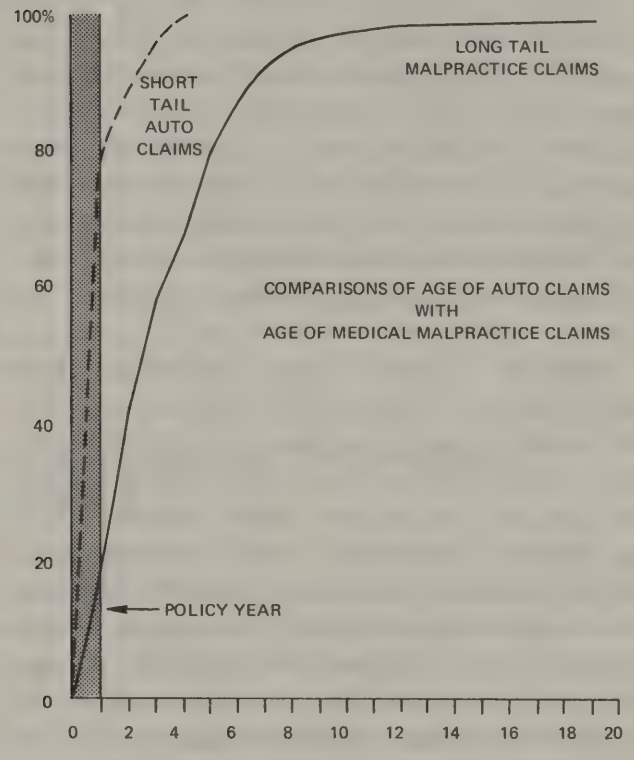
[22] *The Malpractice Insurance Market*, National Planning Association, APPENDIX.

Table 1.—Cost Factors and Expense Experience of ISO Compared to All Medical Malpractice Insurers

Expense category	Factors	
	ISO	Range reported by medical malpractice insurers
Acquisition/production	.25	.05 to .20
Administrative/general overhead	.12	.05 to .12
Miscellaneous	.03	.03 to .05
Underwriting profit	.05	.05
Loss adjustment and losses	.55	.55 to .86

Finally, the most vexing problem for the ratemaker is the protracted period of time that passes before he can know with any degree of certainty what his past experience has been. The following table indicates the impact of the "long tail" on malpractice losses compared with the similar experience for automobile losses:

FIGURE 1



SOURCE: COMMISSION STUDY OF CLAIM FILES CLOSED IN 1970. ESTIMATE OF AUTO CLAIMS BASED ON TESTIMONY.

It can be seen that if it takes more than five years before an average cost per claim can be computed and if the number of claims filed per year and the amount paid per claim is increasing rapidly, then base data, computed on an admittedly small base that is more than five years old, is of little value.

Essentially, this was the experience of the 1960's. One other factor complicates the ratemaking scene. If a company finds that its average cost per claim for 200 claims paid[23] is $3,000 and all of a sudden in year 8 the company must pay a $500,000 award, the ratemaker's projections crumble.

There are many reasons given for the "long tail": (1) court congestion, (2) the long time that it takes for both plaintiff and defense attorneys to prepare their case, (3) both the natural tendency to delay and the sometimes strategic nature of delay by either side.

The most important reasons, however, are in the nature of medical injuries themselves. The statute of limitations, usually two years, places a limit on the time in which a plaintiff must file suit after the incident giving rise to the suit has occurred. However, medical incidents and medical injuries are unique in that the injury may not become known until years after the incident which caused the injury. A classical example is the surgical instrument left in a person during surgery. The "discovery rule" modifies the statute of limitations by saying in effect that the two-year statutory period does not begin to run until the patient "discovers" the surgical instrument in his abdomen. That may be five years after the surgery, so the claim or suit may be filed up to seven years after the surgery took place. The most extreme example involves the child who is injured at birth. In most states, he does not become a "legal person" until he is 21 years old, at which point in time the statute of limitations first begins to run, and the suit may be filed 23 years after the year in which the incident occurred.

The Commission FINDS that medical malpractice insurance rate-setting is complicated by the characteristically delayed reporting of malpractice claims (the long tail problem). As a result, the magnitude and severity of losses for a given premium year are difficult to predict with any accuracy. In turn, the rates arising from this process have frequently proved to be inaccurate.

Grouping Physicians and Institutions

Until about 15 years ago all doctors—whatever their specialties—paid the same malpractice premium rate. However, because some specialties, such as anesthesiology and orthopedic surgery,

[23] Costs are also incurred for claims not paid, often more than the average if the claim is defended all the way through the appeals stage.

have experienced either higher numbers of claims, or higher judgments (or both), carriers began classifying rates by specialty. Several broad classifications were developed: doctors who perform no surgery, doctors who perform minor surgery, doctors who perform major surgery, and doctors in specialties that are considered most hazardous.

Several years ago, the insurance industry began the major job of separately classifying specialties. The following tables illustrate the five categories used by the Insurance Services Office and the relative differences in rates which have occurred from 1966 to 1972. These categories are illustrative. Some companies have many more; one has 17 categories.

Table 2.—The Ratio of the Base Rate For Class Two, Three, Four, and Five Physicians and Surgeons to the Base Rate For Class One Physicians, 1960-1972

Year	Class*				
	1	2	3	4	5
1966	1.00	1.25	2.40	3.60	n.a.
1967	1.00	1.75	3.00	4.00	5.00
1968	1.00	1.75	3.00	4.00	5.00
1969	1.00	1.75	3.00	4.00	5.00
1970	1.00	1.75	3.00	4.00	5.00
1971	1.00	1.75	3.00	4.00	5.00
1972	1.00	1.75	3.00	4.00	5.00

*There are exceptions to these ratios, most notably, New York City (1969-1972). However, they are correct for most rating territories in most years.

The class definitions are (ISO, 1972):

Class 1. Physicians who do not perform or ordinarily assist in surgery;

Class 2. Physicians who perform minor surgery or assist in major surgery on their own patients;

Class 3. Physicians who perform major surgery or assist with major surgery on patients other than their own, plus opthalmologists and proctologists;

Class 4. Cardiac Surgeons, Otolaryngologists—No Plastic Surgery, Surgeons—General, Thoracic Suregons, Urologists and Vascular Surgeons.

Class 5. Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists-Plastic Surgery and Plastic Surgeons.

Source: ISO (1966-1972).

More equitable rate structures could probably be devised if a more refined statistical base were available. The Commission heard from individual doctors who believe that special circumstances should be taken into consideration. For example, the teaching physician who has a part-time private practice does not have the same risk exposure as his colleague who has a full-time private practice. Many physicians in low-risk categories also feel that their premium rates are unfair simply because claims against them have been so few and so low.

The Commission is concerned that the present rating system may cause physicians in some high-risk fields to change specialties or to retire early. High rates may also have a bearing on a young doctor's decision to enter one specialty rather than another. If physicians avoid certain specialties because of high malpractice insurance premiums, the result could adversely affect patient care.

The Commission FINDS that the present methods for establishing malpractice insurance rates, including groupings of physicians and institutions for rating purposes, may not be equitable for all providers or in the best interests of the public.

The Commission FINDS that health-care providers by encouraging numerous separate specialty rating classifications have contributed to the establishment of a rating classification program which may be inequitable to some practitioners and which under some circumstances may adversely affect the cost and availability of professional liability insurance.

The Commission RECOMMENDS that the American Medical Association, American Osteopathic Association, American Nursing Association, American Dental Association and the American Hospital Association meet with the leaders of the insurance industry to study alternative methods of classifying individual practitioners and institutions for rate-making purposes; for example: on a group basis to the medical staff of a hospital or to a county society.

Institutional Rating

Traditionally, hospitals have been rated as individual institutions and their malpractice premiums have been based on their individual claims experiences. While this appraoch has created an incentive

for each institution to concentrate on its own improvement, unfortunately it also has led to wide discrepancies from hospital to hospital in monitoring the quality of care. Some hospitals are extremely conscientious in carrying out patient safety programs. Others choose not to report some incidents or conceal relevant information on incidents in order not to jeopardize their insurance rates or eligibility.

In 1953 the California Hospital Association adopted the approach that medical malpractice is an industry-wide problem—not merely an individual hospital problem—and a group program was developed in which every hospital in a given area was rated on a level-premium basis, no matter what its individual claims experience had been. Rates charged participating hospitals were (and are) based solely on the number of beds and/or outpatient visits. Prior to development of the group program, which now includes 400 out of 600 eligible California hospitals, it was found difficult to develop a proper individual rate for hospitals for a variety of reasons. A hospital might have several years without any adverse claims experience and then suddenly encounter a flurry of significant losses or one very sizeable claim.

Another argument favoring the level premium concept was that an individually-rated hospital, when faced with a judgement which might set a precedent for future judgements, was not willing to take the risk involved and often chose to settle rather than litigate the case. When the risk involved in a test case is shared by every member of the group program, individual hospitals have a greater incentive to fight risky claims.

The California Hospital Association, after many years of experience, has analyzed its statistics on claims based on groupings by size, type, and geographical situation, and has found no significant differences between hospitals upon which to base premium rates, except in the case of teaching hospitals. These results have reinforced the Association's belief in the wisdom of the level-premium concept, which appears to have fulfilled its stated objective.

The Commission believes that the level-rating approach merits further study and possible replication by other hospitals in the best interest of overall patient care.

The Commission RECOMMENDS that serious consideration be given to establishing level premium rates for hospitals within a distinct area based on the number of beds and/or outpatient visits.

Data Collection and Analysis

The National Association of Insurance Commissioners' Industry Advisory Committee on Medical Malpractice recently stated that "central data collection (not rate making) is a prerequisite for decision-making in the malpractice area."

The only agency routinely collecting malpractice claims data from more than one company is the Insurance Services Office (ISO) of New York. ISO is a service organization and not all companies are members of ISO, although some do report data who are not members. Strictly speaking, ISO does not "make" rates but it supplies so-called loss-dollar experience figures from which carriers construct their own rates.

Some individual companies have their own fairly sophisticated reporting systems, but since the total size of the market is small, any one company's data is insufficient for establishing a truly valid data base for rating purposes. In addition, medical malpractice is usually a minute part of a carrier's total business. Thus, it may not command the same attention that other lines do. The same is true for ISO, since it also performs the same services for all lines of insurance.

State insurance commissioners have authority to require statistical reporting within their states, but there is no requirement for uniform filing. Except in the larger states, most state insurance departments are not equipped or staffed to monitor malpractice data effectively.

There was concern among some Commission members that rate-making on the basis of national data could work to the disadvantage of health-care providers and institutions in some states.

The Commission believes that latitude should be built into any rate regulating program. Companies should be encouraged to use their ingenuity to develop new and improved programs toward the objective of the most equitable rates possible for all.

The authority of state insurance commissioners

varies from state to state, and in lieu of Federal legislation requiring national uniform reporting, the Commission believes that a feasible method of organizing such a system would be to work through the National Association of Insurance Commissioners.

The Commission agrees that basic data should be made available not only to the insurance industry, but to all other interested parties.

The Commission FINDS that inadequacies in the collection and analysis of appropriate data have precluded the development of sound actuarial practices and rates, and that state insurance departments are generally inadequately equipped to monitor effectively the rate-making process employed in establishing malpractice insurance rates.

The Commission RECOMMENDS that the National Association of Insurance Commissioners work with the insurance industry to establish a uniform statistical reporting system for medical malpractice insurance and that data be reported to a single data collection agent who will compile it, validate it and make it available to state insurance regulators, carriers and other interested users.

Marketing Malpractice Insurance

The lack of adequate communication between the industry and health-care providers too often causes individuals and groups to purchase insurance that is inadequate for their needs. The Commission urges responsible carriers to make efforts to educate health-care providers about the other services that are a part of good malpractice coverage. For example, the best carriers conduct active, effective loss-prevention programs and handle claims both promptly and fairly. We believe that providers should keep such factors in mind when purchasing insurance. To make it easier for the purchaser, the Commission believes that carriers should make information about loss-prevention programs and claims handling available to health-care providers.

The Commission RECOMMENDS that the insurance industry develop improved channels of communication concerning the marketing, economics, and quality of medical malpractice insurance so that responsible sources of medical malpractice insurance are more widely known to health-care providers, insurance brokers, and independent insurance agents.

The Commission RECOMMENDS that purchasers of medical malpractice insurance, especially associations and institutions, give due regard to the loss-prevention and claims-handling capabilities of prospective insurance carriers, and that active programs be instituted and encouraged in cooperation with insurance carriers designed to prevent the occurrence of injury as well as to assist in disposing of meritorious cases as quickly and as fairly as possible.

The Commission RECOMMENDS that states require insurers issuing medical malpractice policies to disclose loss-prevention and claims settlement practices on request by purchasers and in any sales promotional material distributed to prospective purchasers.

Medicare and Malpractice

A substantial portion of the money spent in this country for health care comes from the Federal government. To the extent that the malpractice problem is adding to the cost of health care, the public, through taxes, is bearing a significant part of the burden.

Under its charter, the Commission was directed to examine the relationship and impact of the malpractice problem on direct Federal and Federally-supported programs. Accordingly, since approximately $5.5 billion was paid out in Medicare Part A claims alone for fiscal year 1971, focus on Part A of the Medicare program, by way of a good example, seemed in order. (Title XVIII of the Social Security Act [Medicare] consists of two programs: Part A, covering hospital, extended care and home health benefits; and Part B, which covers physician and other related medical services.)

Between 17 and 18 percent of the 12,000 patients represented in the Commission's survey of medical malpractice claim files closed in 1970 were over 65. This equals the percentage of people over 65 who were discharged from short-term-stay hospitals. The survey also revealed that 11.7

percent of the patients represented in the closed claims files had their medical bills paid by Medicare. What we do not know is whether any of these patients were retroactively denied their Medicare benefits, nor do we know whether a denial precipitated a malpractice suit. It is known, however, that there is a large amount of dissatisfaction with the program, and that this dissatisfaction is caused primarily by the high rate of disallowance of claims, especially retroactive denials, without clear explanation or apparent equity for the denials.

To explore the methodology, therefore, by which Part A Medicare claims are denied, a staff report was prepared for the Commission's consideration.[24] This study examined the claims review procedures employed by 6 intermediaries (from a total of 10 insurance companies and 73 Blue Cross plans) who have been entrusted by statute with the responsibility of determining which beneficiary claims are to be paid and how much will be allowed for various procedures. The study revealed that there is almost no uniformity and little equality in the standards employed by intermediaries in making denials. This is due, in part, to the fact that there are no mandatory, exact directions for the claims review process. Intermediaries generally make their own rules and these rules vary greatly.

Statistics from the Social Security Administration, which administers the Medicare program, show that of a total of 8,585,400 Part A claims processed in fiscal year 1971, there were 215,500 claims denied in full, or 2.5%. This does not show the number of claims denied *in part,* of which there is an even larger number. In addition, in 1971, there were 38,000 formal requests for reconsideration of denials, of which 6,158 claimants went on to request formal hearings; 3,716 went on after the hearings to further administrative review; and 79 sought court action.

The Commission considered at length the staff report on Medicare and believes that all parties involved in the Medicare program should have their attention directed to the findings in that report.

The Commission RECOMMENDS that Congress and the Secretary of Health, Education, and Welfare thoroughly investigate the findings reported to the Commission relating to the denial of claims under the Medicare program and their relationship to the malpractice problem.

[24] *Medicare and Malpractice,* Evelyn Bradford, APPENDIX.

Table 3.—Medicare, Part A, Claims Processed and Denied in Full From July 1970 to June 1971 by Type of Facility

	Processed	Denied	Percent denied
Inpatient hospital	6,779,500	52,500	0.8
Extended Care Facility .	805,500	125,200	15.5
Home Health Care . . .	1,000,400	37,800	3.8
Total	8,585,400	215,500	2.5

Because of the absence of hard data to show the effects on the malpractice problem of the breakdown in the provider-patient relationship which may be produced by Medicare denials, the Commission does not feel qualified to make specific recommendations concerning detailed improvements in the implementation of the Medicare program. Nevertheless, the Commission recognizes the fundamental fact that, to the extent that breakdowns in provider-patient relationships are due to the operation of the Medicare program, a level of consumer frustration may be created that is conducive to malpractice litigation. The Commission is also cognizant of the fact that the Medicare Amendments passed in December, 1972, were intended to alleviate some of the Medicare problems; on the other hand, they may well increase them because of the complexity of the statutory language and the administrative difficulties which may arise out of their implementation.

The Commission RECOMMENDS that Congress and the Secretary of Health, Education, and Welfare review those portions of Title XVIII of the Social Security Act (Medicare) which contain benefit-payment restrictions and other limitations that impede patient rapport and which may tend to increase the number of malpractice claims. The Commission urges reevaluation of Title XVIII so that patient frustrations are reduced to the extent feasible.

The Commission RECOMMENDS the launching of an educational and public relations program aimed at Medicare participants in order to increase understanding of the program's statutory limitations and to decrease public dissatisfaction and frustration which may lead to malpractice claims.

Although the Commission limited the foregoing recommendations to the Medicare program, we are aware that similar problems of patient dissatisfaction can and undoubtedly do stem from private health insurance programs. We believe that dissatisfaction due to financial difficulties connected with denial of benefits under private health insurance contracts are equally frustrating and may, when coupled with other irritations, generate some malpractice claims and suits. No specific study was undertaken in this area, primarily due to time limitations, a problem which affected all of our research efforts.

Measuring the Costs of Medical Malpractice

Although the precise costs of medical malpractice to Federal and state-financed or supported health-care programs are not known,[25] certain substantial factors were identified which require additional research. For example, the direct costs of malpractice insurance are identifiable and reimbursable under Medicare and other reimbursement programs.

Indirect costs, which are not presently identified, should also be analyzed. These include the cost of using hospital personnel for claims investigation or as witnesses; and the cost of preventive actions or procedures that may be solely related to avoidance of litigation and not directly to patient care. Another important indirect cost is incurred through the providing of remedial hospital or medical care to persons injured due to malpractice, to the extent that their health coverage benefits cover these items. As a practical matter, in any serious case one could assume that there is substantial coverage. Finally, there are the indirect costs of the additional care to the patient and such other costs as may result from unnecessary medical care or procedures caused by the practice of defensive medicine. The doctor probably does not include a cost factor for loss of productive time by himself or his staff for participating in litigation, however, it should be pointed out that some physicians now carry insurance for at least partial coverage for this loss of income and such insurance becomes a part of his overhead.

The Commission is of the opinion that the true impact of the malpractice phenomenon on Medicare and other Federally-supported health care programs, is both complex and significant. In-depth analysis should also be made to identify the cost of overlapping benefits so that these resources can be used to provide more complete coverage to all. No new Federal program should be initiated without taking these factors into consideration and all existing programs should be reviewed to achieve these objectives.

The Commission recognizes the need to measure and evaluate the impact of malpractice claims and litigation on the costs of Medicare and other Federally-supported health-care programs and the Commission, therefore, RECOMMENDS that appropriate studies be initiated to achieve that objective. Such analysis should include not only the premiums involved but the costs of handling claims and the costs to other Federally-sponsored programs that may also be providing benefits to medically-injured persons.

Other Health-Care Programs

Each of the major national health insurance proposals introduced in the 92nd Congress was designed to pay for health-care services provided to the public by the private sector. Their purpose was to make health care accessible to all Americans and to lessen the financial impact of catastrophic illnesses. One characteristic is common to all the proposals. *They are medical care financing schemes, not schemes to provide health care.*

As with Medicare and other third-party payment plans, these national health insurance proposals would not alter the relationship between the

[25] Assuming a per diem cost for hospital malpractice insurance of 50¢ per bed per day, and a per bed rate of $100 per day, the cost of malpractice insurance alone would approximate $27.5 million per year for Medicare Part A in 1971.

physician and patient or the hospital and patient. As financing schemes, these proposals would not change the malpractice liability of the health-care provider who would still be subject to claims from patients who believe they were injured by medical treatment.

Some subtle changes could be expected that might increase or decrease the number of claims. On the one hand, the total number of claims might be increased, simply because more people would be receiving health care. On the other hand, the number of claims might be reduced because treatment for medical injuries incurred would be paid by national health insurance, thereby reducing the economic impact of an injury. The Commission believes that the Government, in establishing national health insurance, should look to past experience. The complex benefit structure and the cumbersome administrative procedures of Medicare that tend to frustrate both the patient and the provider should be avoided in any national health insurance scheme.

The Commission FINDS that current national health insurance proposals are payment mechanisms similar to Medicare and private health insurance. They expand government involvement as a third party payer for health care. Health insurance, whether public or private, does not alter the liability of the health-care provider; health-care providers would still require professional liability insurance, and they would still be subject to claims and suits filed by patients who feel they have been injured due to malpractice. Thus, the findings of the Commission with regard to Medicare also apply to other third party payment mechanisms, existing or proposed, governmental or private.

The Commission FINDS that third party payment mechanisms with unnecessarily complex benefit structures and laborious administrative procedures adversely affect the provider-patient relationship.

The Commission RECOMMENDS that new third-party payment proposals, such as national health insurance, have benefit structures which are easily understood by patients and providers and that the administration of such plans be as simple as possible to avoid, to the extent possible, retroactive denials of claims and other administrative impediments which might exacerbate the patient-provider relationship and create an environment conducive to disputes, claims and suits.

Coordination of Health Insurance Benefits

Some Americans have multiple health insurance coverage. A man over 65 is eligible for Medicare; if he has not retired he may have coverage as a part of his wages and related benefits both for himself and his wife through his employer; while she, working for a different company, may also have similar coverage for both from a different insurer. The couple may be able to recover the costs of a single illness or injury several times from various sources. In the event of a successful malpractice action, they may add to their gain from health insurance, the amount of any settlement or award.

Most health insurance programs coordinate with others to limit recovery from all insurance sources to 100% of the cost of an illness or injury, but this is by no means universal. The Commission was unable to determine how much of the money paid out of publicly-supported programs, such as Medicare, is duplicated by payments from private insurers. Nor were we able to determine how much of the money that is paid out in malpractice awards and settlements goes to "cover" medical and hospital costs that have already been paid for, but such duplication, to the extent that it occurs, also obviously adds to the cost of malpractice insurance.

We believe that health insurance benefits should be coordinated so that the patient is recompensed in full for his covered costs, and that the excess government funds now paid for multiple coverage should be used to increase benefits in order to provide more coverage to all. Since the major portion of these costs is being borne by the Federal Government, it should take the lead in this matter.

The Commission believes that the Federal Government has a duty to perform a leadership role to encourage the coordination of health insurance benefits from whatever source, both to assure

the patient of maximum benefits and to avoid duplication of coverage with its additional costs.

The Commission RECOMMENDS that an indepth analysis be made to identify the cost of overlapping health insurance benefits and to identify the methods of using these resources to assure more complete coverage to all. No new Federal or Federally-funded program should be initiated without taking these factors into consideration, and all existing programs should be reviewed to achieve these objectives.

Chapter 5

Prevention of Medical Injuries

As we have noted, medical malpractice claims are primarily caused by injuries or adverse results of medical treatment. Therefore, major attention must be given to finding ways of preventing or minimizing the frequency of such injuries and adverse results. Improvement of patient safety is—and must remain—the primary concern of all who are seeking solutions to the malpractice problem. What are the means by which this can best be accomplished? Reducing the risk of medical injuries and other adverse results of treatment requires cooperation of all persons involved in providing patient care, and in this chapter we discuss how we believe this can be accomplished.

First, we focus on ways to reduce the likelihood of negligent treatment, including ways of improving regulatory mechanisms, principally licensing practices and regulation of staff privileges. We next look at the training or education of health-care providers, and recommend improvements. Finally, and perhaps most important of all, we focus on ways to reduce injuries themselves, and the techniques most likely to achieve that objective.

Malpractice and Licensure

The Commission discussed at length the questions of licensure and professional discipline as they relate to malpractice. We agreed that they are indeed related; that more effective programs of licensure and discipline cannot help but have a favorable impact upon the incidence of malpractice.

The major stated purpose of licensing health professionals is to protect the public by assuring minimum standards of competence. A consensus emerged among us that the relationship between incompetence and malpractice is far from one-to-one: competent practitioners are sometimes sued and incompetent ones often not. Nevertheless, manifest incompetence, demonstrated by a pattern of practice, necessarily results in harm, whether or not claims result.

At the outset, a double warning is necessary. Firstly, in this section the Commission of necessity focuses on the failures and inadequacies of the present system of licensure and regulation, a fact which might lead a reader to assume that we believe professional self-discipline to be nonexistent or that most medical practitioners provide

substandard care. We believe no such thing. On the contrary, we believe that most physicians conduct themselves with propriety and demonstrate a high degree of skill and motivation in caring for their patients. The following discussion reflects our attempt to find ways to deal with the small minority who create the potential for malpractice litigation because of outright incompetence or other professional inadequacy.

Secondly, we do not use the term "discipline" in the negative sense of punishment. Rather, we view it as a positive system for assuring and maintaining a high level of performance by all practitioners.

Licensure laws presumably can affect the quality of care by (1) setting educational standards for entrance into a profession; (2) exercising discipline over licensees; and (3) requiring periodic evidence that the professional has maintained his competence. Physicians are examined and licensed by State Boards of Medical or Osteopathic Examiners whose members are appointed by the Governors. Other health professionals, such as dentists and nurses, are licensed by analogous but separate boards. In practice, once a physician's license has been granted, it is good for a lifetime. Unless the holder is convicted of a crime or held to be guilty of some form of gross misconduct, his license is renewed automatically upon the filing of a form and payment of a fee, and in some states without even that.

For many years, most of the available time of the State Boards was consumed by writing and giving examinations. With the advent of the examinations given by the National Board of Medical Examiners and more recently of the Federation Licensing Examination (FLEX), this burden has been much eased. FLEX is sponsored by the Federation of State Boards of Medical Examiners and is now accepted by more than 40 states. The examinations are not identical, however. The states are supplied with a pool of questions and each chooses which ones it wants to ask. Each state also sets its own passing grade.

Relieved of the burdensome chore of having to write their own examinations, State Boards now have much more time to devote to their second major function: assuring the maintenance of standards of proficiency and conduct of licensees—a disciplinary function. Both the diligence with which Boards undertake this task and the grounds upon which they may act very widely from state to state. Significantly, only 15 states permit a license to be challenged on the ground of professional incompetence. An analysis of 342 disciplinary actions that was presented to us showed that the largest number—43%—were for offenses connected with drugs and almost all the rest for a scattering of other charges. There were only 12 cases in which the charge was professional incompetence. State Boards generally appear to be limiting themselves largely to policing cases of criminal conduct or moral turpitude rather than to monitoring the quality of practice. A change of emphasis in the interest of patient care appears to be in order.

The infirmity of state laws (some of which have not been updated since they were enacted many years ago) is viewed by the Commission as a serious impediment to the assurance of high-quality medical care. The law in most states permits conduct which, though it may not be criminal, nevertheless may result in needless harm to the patient and consequently lead to malpractice litigation. This deficiency must be remedied.

The Commission FINDS that the competence of individual providers of health care affects the overall quality of care. The Commission also finds that most State medical practice acts do not have adequate provisions for disciplining practitioners who have been found incompetent.

The Commission RECOMMENDS that all State medical practice acts include specific authority to State licensing bodies to suspend or revoke licenses for professional incompetence.

Maintaining Competence

In this rapidly changing world, the physician who does not keep up to date quickly becomes obsolete. The graduate of 20 years ago need not know everything that is required of today's students, but he must know current practice in his own specialty. An orthopedist need not know how to treat all kidney diseases, but he should know how to spot the possibility of renal complications in his patients and know when to call for consulta-

tion. He certainly had better know the proper way to pin broken bones.

Hence the flowering of continuing education. Hospitals, medical societies, commercial sponsors and medical schools all offer a proliferating variety of courses designed to help the practitioner keep up to date. Some medical societies and specialty groups are beginning to establish certain minimum continuing education requirements as a condition for maintaining membership.

The Commission deals with the subject of continuing education later in this chapter. Here it is enough to point out that the weakness of such voluntary programs is the age-old one of human nature: it is the most thoughtful and conscientious individuals who take the courses; the less motivated and careless, who may need them more, are less likely to do so, even though their ignorance may increase the likelihood of malpractice suits against them. The rationalization that they are overworked and "can't spare the time" deters many, and the threat of being dropped from membership in a medical society may not provide a strong enough impetus for such people to maintain their proficiency; a stronger prod is needed. Moreover, those who presently do take the courses are rated only for attendance, not for substantive knowledge.

In New Mexico and Maryland, state law permits the Board of Medical Examiners to "establish mandatory continuing education requirements for physicians licensed in this state." The Commission believes that this is a sound idea, and that these two states have set an example worthy of emulation by all the others.

The Commission RECOMMENDS that the states revise their licensure laws, as appropriate, to enable their licensing Boards to require periodic re-registration of physicians, dentists, nurses and other health professionals, based upon proof of participation in approved continuing medical education programs.

Enforcement Delayed

A major problem brought to the Commission's attention is that a State Board's efforts to discipline an offender may be thwarted for months, or years, by dilatory court proceedings. A Board may revoke the license of a doctor who may then, perhaps on that same day, seek relief in court. There, in an *ex parte* proceeding,[1] he may obtain an order staying the revocation and may continue to practice. The purpose of this kind of order is to prevent irreparable harm from being done to the doctor before he has had a chance to have the case fully reviewed by the court. We agree that the rights of a doctor who may have been treated unfairly by a Board must be protected, but we are equally concerned about the rights of the patients whom *he* may irreparably injure while license revocation stay orders remain in effect.

The Commission heard a number of "horror stories." In New Mexico, the Board found that two doctors were guilty of fraud and revoked their licenses. The courts held up the revocations for nearly two years and during that time the pair accumulated $1.5 million in malpractice suits. At our Denver hearing, we were told of a physician who, during the period of a license revocation stay order, was said to have been "definitely responsible" for at least two patient deaths, perhaps responsible for two others, and who allegedly caused permanent injury to two more people. In a California case, a defendant was charged on June 17, 1966, with "gross incompetence." It was not until September 29, 1972, six years and three months later, that a final court order suspending his license for 90 days and thereafter restricting his privileges became effective.

The Commission agrees that the repetition of such incidents must be prevented. License revocation is the last resort of State Boards. Almost invariably it is preceded by several warnings, attempts at rehabilitation and other less extreme measures. Invariably, a revocation order is preceded by a hearing at which the doctor presumably had a full chance to present his defense. The only real difference among us revolved around the question of whether such a provider should be allowed to practice for any time at all after his license has been revoked by a State Board, unless it can be shown in an adversary proceeding in court that the possible damage to him outweighs the possible harm to his patients. In an *ex parte* proceeding, the

[1] In an *ex parte* proceeding only one side ordinarily appears.

doctor and his counsel speak for him, but there is no one to speak for his patients.

In the Federal courts an *ex parte* stay order may be issued, but typically, an adversary hearing is held within 10 days. Only after the court has heard both sides will it grant a stay order for any longer period of time. In State jurisdictions, however, the time lag may be and often is longer. We believe that the rights of both doctor and patient must be protected and that, in cases of license suspension or revocation, this can best be done when an adversary hearing is held *promptly* on the question of whether the suspension or revocation shall be stayed.

The Commission RECOMMENDS that the states enact legislation which limits the duration of judicial *ex parte* stay orders to the minimum period necessary to hold an adversary hearing in cases of suspension or revocation of licenses of health professionals by State Boards. The adversary hearing should be given priority on any court docket.

Rehabilitation—The Positive Side of Discipline

As we have indicated, we believe discipline to be a positive technique for assuring the competence of practitioners. If a physician is stretching the limits of his ability, if he has been "too busy" to keep up with his specialty, if he has been drinking too heavily, it is surely better, when possible, that the helping hand of his peers bring him into line than that he be cast aside and the public be deprived of his services.

Probation is a very useful tool for accomplishing this. Most persons—faced on the one hand with the loss of livelihood and on the other with a friendly lift out of trouble—will make the obvious choice. When a State Board can order a surgeon who has been performing operations beyond his competence to restrict his practice, or a physician who has fallen behind the times to take additional training, both the doctor and society gain. We believe that if there must be expulsion, let there be expulsion, but first let us make a real try at improvement.

The Commission RECOMMENDS that State licensing laws emphasize the rehabilitation of practitioners who have been found guilty of infractions.

The Commission RECOMMENDS that State Boards of Medical and Osteopathic Examiners be authorized to prescribe a range of intermediate disciplinary actions in addition to suspension or revocation of licenses, such as requiring remedial education.

A National System of Licensure

The lack of uniformity among state medical practice acts and the absence of effective communication between the states on disciplinary cases was brought forcefully to the Commission's attention. Only eight states have provisions of law that will permit them, after hearings, to act against a practitioner whose license has been revoked in another state. An instance was cited to us of a physician who sought a license in New Mexico, although 12 malpractice actions had been brought against him within the previous year in California. The New Mexico Board ordered a hearing at which the doctor would have to show cause why he should be licensed. In the end, the license was not granted, but in many places it would have been.

Another problem arises from the fact that the standards for initial licensing are lower in some states than in others. While the Commission feels strongly that the residents of all states are entitled to doctors of the highest quality, a practical problem was pointed out. Some of the states with lower standards need doctors so badly that they feel they simply cannot afford to exclude even a few physicians by raising licensing standards too far. Better, they feel, to have a somewhat less qualified physician then none at all.

Thus, while a single national examination and licensing system might solve some problems, it might also create others. In our limited time and with limited information, we do not feel competent to make a final judgment on this matter, but we do feel that it should be thoroughly explored.

The Commission RECOMMENDS that a feasibility study be made regarding the establishment of uniform national procedures for examining

and licensing health professionals, and the establishment of uniform standards of practice.[2]

Re-evaluation and Re-certification of Specialists

Beyond licensure, the competence of American medical specialists is certified by the various specialty boards. While a license to practice legally permits a physician to give any treatment or perform any operation, the profession itself has moved far beyond that point in setting standards. The specialty boards regulate and approve training programs to assure that a physician whom they certify is qualified to act as a specialist. Board certification means that a surgeon has undergone additional years of special training, and has met the strict standards of his specialty. But even the specialist needs to keep up to date, and a strong movement to require him to do so is gathering steam within the profession.

As a man practices a specialty, his interests tend to focus more sharply; his abilities both narrow in scope and increase in depth. As he forgets more and more of what he does not need to know, it is to be hoped that he gets better and better at what he does. His peers, by a reasonably simple assessment, perhaps an oral examination, can well evaluate his continuing competence. They should be encouraged to do so at regular intervals. An impressive certificate hanging on the doctor's office wall leads the patient to think that the physician is highly competent. We believe that he should maintain that competence to retain that certificate.

The Commission RECOMMENDS that specialty boards periodically re-evaluate and recertify physicians they have certified.

Lay Members on Licensure Boards

When State Licensing Boards were concerned principally with writing and giving examinations, it made sense that their membership be composed entirely of professionals. Today, however, as we have noted, that technical aspect of the Boards' work has decreased and there is both time and a compelling need for Boards to move more strongly into the field of discipline. Here the public has a vital interest and we believe its voice should be heard. Some states have recognized this by requiring that certain State officials be *ex officio* members of licensing Boards. California goes further by requiring a public member who is neither a member of the licensed profession nor a State official.

We believe that this is a good precedent. While laymen obviously cannot sit in judgment on the technical performance of doctors, neither should doctors be the sole judges of the *effects* of their professional performance upon laymen. Both must be heard.

The Commission RECOMMENDS that all state licensing boards include lay members.

Open Disciplinary Hearings

The Commission found itself upon the horns of yet another dilemma. A patient may well desire privacy about his or her medical problems and a doctor obviously would prefer not to be pilloried in public for his alleged mistakes. Yet justice must not only be done, it must be *seen* to be done. Otherwise there will always be suspicion. Whatever the outcome of a disciplinary hearing by a State licensing board, if it is held in private there is always the possibility that one Board might "whitewash" a doctor, while another might "railroad" him. In the interest of fairness, both to the accused physician and the general public, such proceedings should not be conducted behind closed doors.

In some states, all formal hearings by law are open to the public. This does not mean that preliminary stages, such as the investigation of possibly unfounded charges, or Board deliberations while formulating decisions are open, any more than grand jury investigations or trial jury deliberations are open. It does mean that when a hearing is held and the evidence on both sides is presented, the proceeding should be open to public scrutiny. We believe that the interest of all parties requires no less.

[2] See Dissenting Statement by Monroe Trout.

The Commission RECOMMENDS that all disciplinary hearings be open to the public.

Institutional Licensing

Finally, in this area, we considered the licensing of allied health personnel. The present situation is a jungle and rapidly worsening. Technicians and technologists of many kinds all have their own separate standards of licensure and more are pressing for state licensure laws every day, both to protect the public from incompetence and to enhance and preserve their own positions. In California, for example, there are 21 different licensures for health-care practitioners.

Licensure requirements often limit both the vertical and the horizontal mobility of people: a person rises to the top of one "ladder," but to move to a position of higher status requires starting all over again at the bottom rung of another. For example, a person may become a licensed practical nurse (LPN), but from there on in many states if she wishes to become a registered nurse, she must start all over again, no matter how much training and experience she may have had as an LPN. Conversely, there is underutilization of skills: many jobs in hospitals and medical clinics are required by law to be done by licensed personnel, even though they are simple mechanical tasks which could well be done by people trained specifically to do that one thing.

In the last analysis, the institution bears the main responsibility for the performance of its allied health personnel. If a negligent medical technician causes injury to a patient at a medical center, it is the center that will pay the malpractice bill, whether out of pocket or through higher insurance premiums. Since responsibility and liability rest with the institution, it would seem more reasonable to license the institution rather than the individual.[3]

An institution could well set the requirements for the people it hires, trains and trusts. Such a system would allow for greater mobility among allied health personnel and it would give hospitals and clinics greater leeway in training and using people for the specific jobs they will be doing, thus easing the burden of management and helping to restrain costs.

The concept is new and untested, and there are undoubtedly problems that are not immediately apparent, but the Commission believes that the idea of institutional licensing is well worth exploring.

The Commission RECOMMENDS that studies be made to determine the impact on the quality of care of institutional and organizational licensure for allied health personnel (other than registered nurses) as an alternative to individual licensure.

Several members of the Commission also noted that the employment of foreign-trained physicians and nurses presents a problem in the area of institutional responsibility that is also worthy of study. If a resident doctor does not understand what a patient is saying, or a nurse does not comprehend doctor's orders, the hospital is responsible for any unfortunate consequences.

Suspension of Staff Privileges

Some people are skeptical, even cynical, about the efforts of the health professions to police themselves. If a hospital staff does not act against an incompetent in its ranks, many people tend to think it is a case of like protecting like. Based on the information brought to our attention, we find that this is not necessarily so, but all too often doctors whose staff privileges should be restricted continue to practice unrestrained, either because there are loopholes in the system or because good men fear the law.

Consider the case of a surgeon who has been consistently negligent or incompetent at one hospital: the Chief of Surgery and his fellow doctors decide to bar the man from the hospital. If the doctor has staff privileges elsewhere, losing his privileges at Hospital A will not mean that Hospital B will necessarily know what happened and he may continue to practice there. If Hospital A is the only place where the doctor has staff privileges, then the institution may find itself the defendant in a

[3]See Hershey, N., *An Alternative to Mandatory Licensure of Health Professionals*, Hospital Progress, Vol. 50, p. 71 (March 1969).

lawsuit, with the barred physician seeking not only reinstatement, but monetary redress for his lost income and damaged reputation.

We were told of several such lawsuits in which the plaintiffs had won; in other cases, the courts had ordered that the barred doctor's staff privileges be restored. We also were told of instances where hospitals—aware of misconduct at other institutions—had not even tried to get rid of the incompetent staff member. Fortunately, these instances are rare.

Clearly, if hospitals and their medical staffs are to tackle their own malpractice problems effectively, they must be given some assurance that when disciplinary actions are taken in good faith, the institution will not be held liable to the doctor. Anything less would make hospital disciplinary action an exercise in futility.

At the same time, the physician who is threatened with curtailment or loss of his hospital privileges *must* be assured of his right to a fair hearing. The Joint Commission on Accreditation of Hospitals has incorporated a "Bill of Rights" for such physicians in its general standards. In order to be accredited, a hospital must give him a fair hearing and a right of appeal.

However, we believe that he should not have the right to seek monetary damages because of the honest judgments of his peers so long as those judgments are made without malice. The surgeon who fairly recommends disciplinary action against another surgeon should have qualified immunity, just as the judge or jury who rule on a defendant's guilt or innocence cannot be sued for that decision.

At the present time, approximately half the states have laws that give this qualified immunity to hospital medical staff committees. We believe the other states should follow their lead.

Even when a hospital is successful in restricting, suspending or terminating the privileges of a physician, he often is free to go on practicing somewhere else. While we are concerned with protecting the rights of physicians (in Hospital B he may not be guilty of the actions that got him into trouble at Hospital A), we also are concerned about protecting the rights of the patient. For this reason, we believe that when a hospital takes action against a physician, other hospitals should be notified. At the present time, some hospitals do not tell others what has occurred because of the possibility that the physician in question will file a lawsuit for defamation of character, libel or slander. We believe that a state law requirement could overcome the reluctance of many hospitals to give notice to other hospitals of disciplinary actions taken.

We are not suggesting any innovations to the states. In some states, for example, the nursing profession gives notice to the state licensing board when a nurse is suspended by a hospital or nursing home. The State board then circulates her name to every employer of nurses in the State. This does not mean that the nurse cannot be hired; but it does put the hospital or nursing home on notice about the situation.

The Commission RECOMMENDS that the states enact legislation to authorize, with due process, the appropriate committee of a hospital medical staff to suspend, revoke or curtail the privileges of a physician or hospital staff member for good cause shown. The committee members and the hospital should have qualified immunity from suit for their acts. Notification of such actions should be forwarded to the appropriate state licensing boards.

Continuing Education

Continuing education is important to today's health-care provider both for professional and legal reasons. In medicine, the general legal obligation of the physician to use "reasonable care" in treating his patients imposes on him the duty to exercise the degree of care, diligence, and skill that other physicians exercise under like circumstances. It is the alleged failure to adhere to this standard of conduct which is the underlying issue in nearly every malpractice case. This same fundamental rule of conduct applies with equal force to the acts of other health professionals, such as nurses.

Since the standard of care is directly tied to current practices and the existing state of knowledge, modes of practice which may have constituted reasonable care in the past may not constitute reasonable care today. Thus, the absolute necessity for keeping abreast of changes in treat-

ment modalities is apparent, and continuing education is the means by which this is done.

Current continuing education programs for health professionals may be purely voluntary, may be required by professional organizations as a condition of membership, or may be tied to license renewal requirements by State boards of licensure. Continuing medical education is being fostered with increasing intensity by the medical community. The American Medical Association has established a Physician's Recognition Award for physicians who complete 150 hours of continuing education in a three-year period. Several specialty boards offer voluntary self-assessment examinations which physicians may use to pinpoint their individual deficiencies and choose appropriate areas of study.

While those efforts are voluntary in nature, the Commission takes cognizance of the trend toward mandatory continuing education programs. The American Academy of Family Physicians requires continuing education of its members, as does the American Osteopathic Association. In six states—Arizona, New Mexico, New Jersey, Oregon, Massachusetts and Pennsylvania—the State medical association requires a certain number of hours of continuing education as a condition of membership. Expulsion from membership does not take away a doctor's right to practice.

Only two states have thus far enacted a relicensure law for MDs tied to compulsory continuing education and proof of proficiency, although between fifteen and twenty are said to be considering doing so. Some states have separate licensing boards for *MD*s and *DO*s. Boards that license only doctors of osteopathy make continuing education a requirement for licensure. Statutory requirements for evidence of continuing qualifications as a condition of license renewal have been enacted for optometrists, dentists, dental hygienists and nurses. In California, as of 1975, both registered nurses and licensed vocational nurses will be required to keep current on developments in their fields, either by taking approved courses of by other educationally-equivalent means.

All of these programs have merit and are to be encouraged. However, the ultimate goal of all continuing education efforts should be the elevation of standards of care. The evidence thus far suggests that effective means for evaluating the impact of continuing education on the health-care system as a whole have not been developed. The mere fact that someone has sat through a course is no evidence that he has profited from it. While almost every educational program undoubtedly has some benefits, we know very little about precisely how great those benefits are or about the relative effectiveness of these programs in improving the quality of care. We believe that this deficiency must be corrected.

The Commission FINDS that medical education, at all stages of a health professional's career, has an impact on standards of care, and there is a compelling need for continuous evaluation of its direction, performance, and results.

Ways to Do It

If programs of continuing medical education are to be of any value, they must be practical and relevant to each practitioner's needs in treating his patients. There must be greater emphasis on the quality and effectiveness of such programs, rather than on participation. No single form of continuing education is necessarily superior in every situation, and we believe that less formal, experience-centered approaches may prove to be as effective in given situations as some of the more traditional, formal courses and programs of instruction. Conferences with colleagues in hospital hallways, on grand rounds, and in *ad hoc* consultations, as well as service on hospital tissue, utilization review, medical audit, and death committees, all can play a vital role in the continuing education of health professionals. The objective should be continuing education as an integral part of the practitioner's professional life, and, to the greatest extent possible, it should be patient-problem-oriented.

The Commission takes cognizance of the wide range of accredited educational courses and programs, presently numbering approximately 2,100. A few illustrative programs are described below:

- At Chestnut Hill Hospital in Philadelphia, physicians set medical care criteria, audit medical records to monitor their deficiencies,

determine education objectives, institute appropriate changes in treatment, and then re-audit the results. More than 60 other hospitals are now employing this "Bi-cycle Concept," which was developed by Dr. Clement R. Brown, Jr.

- The so-called West Virginia Plan, developed by Dr. Daniel Hamraty, is also oriented toward better patient care, but in the setting of the physician's office. Physicians set their own criteria for patient care and have their actual medical records audited by a peer physician against the selected criteria.
- Under the University of Sourthern California Plan, developed by Dr. Phil R. Manning, physicians at St. Joseph Hospital in Burbank, California, participate in study groups using individually packaged home study materials prepared by the University of Southern California. Group interaction is the principal teaching method, which is not patient-oriented at this level.

At least one hundred specialty societies and medical associations offer courses, lectures, seminars and conferences dealing with specific areas of interest, and since 1970 the Joint Commission on Accreditation of Hospitals has made it obligatory for accredited hospitals to provide continuing education for medical staffs.

As a Commission, we are in no position to recommend one educational approach over another. We do see, however, a positive need for focusing all such efforts on elevating standards of treatment in areas of perceived deficits in professional training. For example, we urge increased attention to the proper prescribing of drugs, an area in which medical leaders have long noted wide discrepancies between practitioners. The need for increased emphasis on medical-legal education has been brought to our attention on a number of occasions, and we find it desirable to develop more effective ways to eliminate common misunderstandings about the interactive roles of medicine and law. We reiterate that, to the greatest extent possible, the continuing education process should be pragmatic, giving the individual practitioner an opportunity to identify his own learning deficits and build thereon.

The Commission RECOMMENDS that continuing education be directed toward known needs and that it be designed around performance criteria.

Imposing Control

We now turn to a more controversial issue: should continuing medical education be voluntary or mandatory? If the stated objective is improving and maintaining the level of competence of all providers, by what means can they be influenced to engage in continuing medical education programs? The difficulty with a purely voluntary program is the old one of human nature: those who need it most are the least apt to use it. The problem is more acute with respect to solo fee-for-service providers than for those who are more active in an institutional milieu. In his own one-man office, responsibility for maintenance of quality control rests essentially with the conscience of each individual physician. The institutional structure is better suited to the exercise of quality controls through peer review and control over the doctor's use of its facilities.

We see a need for a more concrete mechanism to influence solo as well as institution-based and group providers to assure and maintain their proficiency. Whether the appropriate influencing mechanism should be the Federal government acting under its power of the purse, or State governments acting under their authority to regulate the health professions, or peer review groups influencing hospital privileges, we choose not to decide. It is our considered judgment, however, that self-regulation must give way to more positive means for assuring the updating of qualifications of all health-care providers.

The Commission RECOMMENDS that there be imposed upon the existing system of self-regulated continuing education control mechanisms which will require continuing medical education and evidence of provider proficiency.

The Commission's interest in seeking improvements in continuing education was paralleled by its interest in modifying selected parts of the core curriculum for health care professionals. There is

need for improvement in several areas, as discussed below.

Proficiency In Handling Drugs

It was pointed out to the Commission that many malpractice claims arise out of errors in medication, sometimes committed by the physician who prescribes a drug and sometimes by the nurse who administers it. New drugs, new uses for old drugs, new combinations and new variations of drugs make it difficult for the busy practitioner to keep up with all of those that might be useful in his practice. Not only must the doctor know the actions of a drug and the indications for its use, but he must judge the dosage required, observe the effects upon the patient, and adjust therapy accordingly. Nurses have an equivalent need for understanding the uses and actions of drugs.

The Commission understands that the study of clinical pharmacology is elective in some medical and nursing schools. It is our considered opinion, however, that the practitioner who prescribes or administers drugs therapeutically should have a thorough understanding of the subject.

The Commission RECOMMENDS that clinical pharmacology (i.e., the teaching of the actions, indications, side effects, etcetera, of drugs used therapeutically) be required as part of an integrated program for teaching the basics of therapeutics to all medical and nursing students and that similar attention be given to the same subjects in postgraduate and continuing medical education curricula.

Using More Nurses

The Commission fully recognizes the importance of the professional nurse in patient care. The professional nurse still has the primary responsibility for supervising the therapy and patient care prescribed by the doctor. The trend in recent years has been to restructure many of the tasks which make up patient care in order to utilize people who do not require the same amount of training as professional nurses. The Commission is concerned with the trend in some areas to replace rather than supplement the professional nurse with paraprofessionals. The Commission believes that the lack of an adequate number of professional nurses to supervise and provide patient care can increase the likelihood of error and malpractice litigation.

The Commission RECOMMENDS that physicians, hospitals, nursing homes and other institutions increase the number of professional nurses giving direct care to patients in the interests of better patient care and of minimizing malpractice suits.

Clinical Training of Nurses

The education of nurses was also considered by the Commission. In the past, nurses were educated in diploma schools, operated by hospitals, where much of the training was at the bedside. Today, nursing education has been expanded to colleges and junior colleges, where students work for associate or bachelor's degrees and receive only part of their training in the hospital. Their patient care activities tend to be more limited than is desirable. The Commission believes that such nurse-graduates should have sufficient clinical training to be competent and safe practitioners when they enter full-fledged service in the hospital.

The Commission RECOMMENDS that in the interests of better patient care and of minimizing malpractice suits, nurses should be required to complete clinical practice courses in the areas of planning patient care, assessment of patients' problems, recording and reporting, clinical nursing procedures, working with other medical personnel, and educating patients in implementation of doctors' orders.

The Commission believes that nurses should have better grounding in all clinical nursing subjects, particularly human anatomy. More than mere clinical training is needed, however, if the nurse is to provide optimum care to her patients. The sick patient is dependent upon hospital personnel to look after his smallest and most personal needs. He expects warmth and compassion, as well as attention to his physical needs. Psychological factors are as significant to recovery as are therapeutics.

Regardless of how skillful their medical treatment may be, patients often complain that the hospital care they receive is hastily or perfunctorily given, that personnel are cold, unfeeling and unresponsive.

The Commission also believes that all hospital employees who deal with patients, especially nurses, should have an understanding of psychology and the art of human relations in order to enhance patient satisfaction and prevent complaints.

The Commission RECOMMENDS that clinical courses which include human anatomy, psychology, and human relations be required in the nursing curriculum.

Medical Injury Prevention

Improvements in basic and continuing health-provider education, licensure requirements, professional discipline, and specialty board certification affect or measure quality of care, but do not directly deal with ways of preventing medical injuries and adverse incidents that stimulate malpractice claims.

Medicine has made remarkable scientific and technical advances during the past several decades, and diseases which were once considered incurable can now be prevented, ameliorated, and in some instances cured. But emphasis on medicine's more dramatic accomplishments has tended to mask the heightened risks of many of these procedures, some of which result in serious injury and death—whether or not proper care is given.

Since medical injuries are a prime source of the malpractice problem, what type of remedial action is most likely to ameliorate the problem? It should be obvious that any remedy aimed only at reducing the incidence of negligent conduct will prove to be inadequate from the standpoint of protecting the welfare of all patients. Negligence is only one causative factor, and is probably less significant than has been supposed.

Numerous studies of medical incidents and injuries conducted during the last twenty years have identified medical injuries which are preventable. In some cases these studies have resulted in changes which have prevented future injuries: for example, procedures developed to account for surgical instruments during surgery and the standardization of color coding and unique coupling systems used for anesthetic gases.

The Commission believes that the time has come for the health care industry to make a broad scale commitment to patient safety and the prevention of medical injuries. We believe that the most effective way of reducing the frequency of injuries and other adverse incidents is the development of intensive medical injury prevention programs in every health care institution in the country, beginning with hospitals. While not all adverse incidents occur in hospitals, those that prove to be the most serious for the patient are generally hospital-related. Moreover, the organizational structure of the hospital provides the best milieu for initiating effective efforts to reduce the frequency of injuries and other adverse incidents.[4]

It is recognized, of course, that it is impossible to eliminate entirely all medical injuries. Some are unavoidable unless medical care is withheld. Others will occur from human error, since neither physicians nor patients can always avoid error. Any significant reduction in injuries, however, would be beneficial.

Injury prevention programs should focus on every potential source of injury to patients, including medication errors, slips and falls, faulty medical equipment, inadequate supervision of personnel, break-downs in communication, unnecessary surgery, inadequate record-keeping, and other sources of potential harm—whether or not related to negligent conduct. As new and more sophisticated methods for preventing injuries are developed, they should be expanded to include medical injury prevention in physicians' offices and other non-institutional settings.

The Commission RECOMMENDS the development of intensified medical injury prevention programs for every health care institution in the nation, such programs to be predicated on the following:

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[4] An excellent exposition of patient safety guidelines is contained in the joint publication of the American Hospital Association and National Safety Council: *Safety Guide For Health Care Institutions* (August 1972.)

1. **investigation and analysis of the frequency and causes of the general categories and specific types of adverse incidents causing injuries to patients;**
2. **development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all persons.**

Safety programs are not without precedent. Industrial safety programs have been with us for a long time. The safety programs which were developed by the aviation industry, the space program, and the Atomic Energy Commission all involved many people with various skills who were functioning in environments where more was unknown than known and where the risks to life and limb were great. Many of the methods developed by these safety programs for identifying persons, situations, procedures, and equipment which are likely to give rise to injury could be utilized in developing the type of patient-safety and injury-prevention programs we believe are so necessary.

Institutional Quality Control Systems

Hospitals presently have many quality control systems, such as incident reporting systems, tissue, medical audit, and infection committees. The standards for accreditation developed by the Joint Commission on Accreditation of Hospitals contain many references to safety, but these references tend to be limited to physical requirements, such as grounding of electrical equipment in areas where anesthesia is administered or lead shielding in radiological service areas.

Sophisticated medical-injury-prevention and patient-safety programs require unified direction. A viable injury-prevention program cannot be the "other benefits" of quality control systems that already exist. And the systems in effect must not be allowed to stagnate.

The Commission RECOMMENDS that institutional quality control mechanisms of all types be constantly evaluated and, where proven desirable, modified so that the information they generate can be fed into a nationwide information system and into continuing education programs.

Loss Prevention

The insurance industry is in a unique position to support the injury-prevention activities of health-care providers through its loss-prevention efforts. To the insurance industry, loss prevention means taking action to bring about a reduction in the number of injuries that may lead to malpractice claims, thus holding down the total cost of claims and, therefore, of premiums.

Leading carriers carry on extensive hospital loss-prevention programs, and periodically conduct safety inspections of the institutions they insure. They provide speakers and loss-prevention material to hospitals on request. One company has produced 41 motion pictures on patient safety. Most companies do not engage in significant loss-prevention programs aimed at the individual practitioner. The following programs illustrate what can be done in this area:

- One carrier, which concentrates on coverage for the physician who cannot purchase insurance through normal channels recently distributed to individual subscribers a compilation of 381 claims that were closed between March 1958 and November 1972. The claims were broken down into types of occurrences, and specific recommendations for avoiding such incidents were given.
- An insurer who writes group plans for state medical societies distributes pamphlets and brochures, based on needs as reflected by incident reports. These publications advise doctors on ways of preventing individual injuries and types of incidents that can result in malpractice claims.

Several years ago, California health-care provider organizations and the insurance industry cooperated in sponsoring a series of meetings throughout the state on prevention of patient injuries and improvement of care. These meetings, known as The California Invitational, concentrated on ways of preventing patient suicides, on ways to reduce anesthesia injuries, on ways of handling surgical

cardiac arrest and emergency cardiac arrest, on ways to combat hospital infections, on ways to reduce maternal and neonatal injuries and infections, and on ways to reduce injuries from injections.

Physicians and nurses, hospital administrators and insurance company representatives participated in these meetings, and the general consensus was that The California Invitational was successful, not only in its stated aim of reducing patient injuries, but also in improving communication between the various health-care disciplines who participated.

The Commission believes that carriers should initiate loss-prevention programs not only for institutions but also for individual physicians. We do not suggest that insurers should limit themselves to the above examples; experimentation should be encouraged.

The Commission FINDS that where genuine cooperation and support of insurance company loss-prevention programs can be achieved, a meaningful reduction in patient injuries can also be achieved.

The Commission FINDS that loss-prevention activities generally are limited to group plans. For the most part activities aimed toward the individual practitioner have been minimal. There is a need for intensified loss-prevention efforts on the part of the medical malpractice insurance industry working with health-care providers and the consumer community.

The Commission RECOMMENDS that the medical malpractice insurance industry develop sophisticated loss-prevention programs based on both injury and claims-prevention techniques. This development will require the active participation of the provider and consumer communities.

At the present time, some carriers do not allocate a specific portion of the malpractice insurance premium dollar to loss-prevention programs. The Commission believes that part of that premium dollar should be set aside specifically for institutional programs. Health-care providers should be kept informed of that amount and should be encouraged to cooperate with the carriers in developing and carrying out these programs.

The Commission RECOMMENDS that a portion of the premium dollar for institutional medical malpractice insurance be specifically identified and allocated towards loss prevention. Health-care providers should implement and monitor the loss-prevention programs developed in cooperation with their insurance carriers.

In addition, we believe that carriers should be encouraged regularly to analyze claims against institutions and to make this data available to their subscribers. The Commission understands that this would be an additional expense to the industry, but we believe that over the long run the industry, the providers and the general public would all benefit. It is our belief as a Commission that the insurance industry has an obligation to help educate the providers—including ancillary personnel, such as electricians, orderlies, custodial staff—in patient-safety and injury-prevention programs. Summaries of incidents would alert hospital personnel to the types of things that are happening so that they can take measures to prevent them from occurring in the future.

The Commission RECOMMENDS that medical malpractice carriers provide analyses of incidents to institutional health-care providers in order to aid the institution's injury prevention programs.

A Nationwide Data Gathering and Information System

Commission studies indicate that there are particular patterns, situations and locations which give rise to claims. Assuming that medical injuries occur in a similar pattern, continuous monitoring and analysis of the locations within hospitals, the procedures, times of occurrence, etc., in which incidents which give rise to claims occur could provide much of the information needed to develop and operate sophisticated injury-prevention programs.

The individual claims experience of a single

health-care provider, even a large hospital, is so infrequent that the information that could be obtained from one or two incidents is insufficient to support a comprehensive injury-prevention program. However, if this information is collected on a nationwide basis, analysis of the aggregate data could provide an etiology of those situations which most often give rise to injuries which result in claims.

The Commission was directed to determine the feasibility, cost and methodology of establishing a nationwide data-gathering capability which would make possible the continuous monitoring of malpractice claims experience and the study of malpractice-related problems. Such a system could be valuable in at least three ways: (a) continuous monitoring could tell us whether the malpractice situation is improving or deteriorating; (b) the data could pinpoint problem areas, suggesting where corrective action might be needed; and (c) the data would be useful in evaluating such corrective actions.

Although considerable effort and expense would be required to devise uniform reporting systems and to collect, sort, and report this information, we believe the benefits to be gained would more than offset the cost. Much of the data required for such a system reposes in such places as the files of insurance companies, hospitals, and medical societies, but it is not being harvested into a composite and nationally-useful whole, partly because no one place has an adequate amount.

The American Insurance Association, formed in 1965 by the merger of the National Board of Fire Underwriters, the Association of Casualty and Surety Companies, and the former American Insurance Association, is a sponsor of the famous Underwriters Laboratories, and it cooperates with the National Safety Council in its program of fire and accident prevention. The Hospital Safety Program is sponsored jointly by the National Safety Council and the American Hospital Association. Thus the structure for insurance industry participation in medical-injury prevention is already in place.

There are other sources of information that would be helpful in developing injury-prevention programs, and to gather such information might be difficult, expensive, or both. An example is the information on cases that lawyers refuse to handle either because the prospective contingent fee would be too small or because there is evidence of injury but not of negligence. Such information would be useful, for example, in estimating the cost and potential efficacy of a non-fault-based medical-injury-compensation system or the necessity for legal aid programs. It might be extremely difficult or even impossible to collect such data, since most lawyers probably do not keep a record of the cases they turn away. We cannot judge how much effort should be expended in this direction.

While we believe that our own and other studies have shown that a nationwide data-gathering capability is both feasible and highly desirable, we do not presume to dictate fine details to those who will operate it. The sources, details, and frequency of reporting should be based on specific uses. We expect that the persons involved in operating such a system will continually weigh the benefits of obtaining certain information against the costs involved and that they will continually monitor the program with a view to improving and refining it.

We considered three basic ways in which such a system might be controlled: it might be run privately, by a quasi-public agency, like the National Academy of Sciences; by the Federal Government; or perhaps by a combination of the three. Under private or Federal control, we believe that the annual cost would not be less than $1 million; a quasi-public agency would probably be somewhat more expensive, since there would be added expenses for establishing the organization and for independent management and policy functions.

We see several drawbacks to private control. There might be conflicts: the information doctors want is not necessarily identical with that desired by insurance companies, while lawyers and the general public may want still other information. A wholly private effort, no matter how well-intentioned, tends to be suspect when the data reported appears to favor the data collector.

Neither can we advocate sole Federal control nor a quasi-public agency that would have no other government input apart from financing. A private-public partnership seems to be the best answer. Information should be provided by all four of the

concerned communities—the general public, the health-care system, the legal system, and the insurance industry. Full advantage should be taken of existing Federal experience, knowledge and capabilities for collecting information.

Presently, health-care information is collected not only by the Bureau of the Census but by several agencies within the Department of Health, Education, and Welfare, including the Medicare and Medicaid programs and the National Center for Health Statistics. We believe that it would be more efficient and economical for one of the existing agencies to add malpractice information to the data it already collects than to establish a new organization for this purpose. This, of course, would not preclude an independent group such as the insurance industry from establishing a complementary, intermediate data collection point to meet some of its own needs, such as developing better information for establishing premium rates and for designing loss-prevention programs.

The Commission RECOMMENDS that health-care providers, consumers, attorneys, and the insurance industry form a consortium to collect and report information relating to medical injuries and medical malpractice to a Federal or Federally-sponsored data-gathering service.

It is further RECOMMENDED that the Secretary of Health, Education, and Welfare convene representatives of these groups (1) to determine the kind of data needed, and (2) through existing data facilities in HEW, to work with private industry to develop the information.

Individual Privacy

A major consideration in establishing any information-collection system is the privacy of the individual. While we are firmly convinced of the value of an information system, we are equally concerned that the system not be used to violate the privacy of individuals—patients or providers. This principle is firmly established in Federal law for Social Security records and income tax returns. Much useful information is obtained from statistical analyses of these records, but no one may go to them to discover personal information about particular individuals. We believe that the same principle should apply in the case of malpractice information.

Even the possibility that individual records might be made public could generate great and understandable resistance on the part of health-care providers to give information to a central system. Some might flatly refuse to do so, and the program would suffer immensely. For these reasons, we are convinced that the privacy of individual records must be maintained and that such records must be immune to discovery proceedings.

The Commission RECOMMENDS that the Congress, by appropriate legislation, confer privacy to the raw data collected for a nationwide medical malpractice data system, comparable to the privacy that has already been accorded to data collected by the Social Security Administration and the Internal Revenue Service.

Federal Assistance For Injury Prevention

The Federal government spends more than one billion dollars annually for medical research alone. Other Federal health expenditures in 1972 including direct care programs, Medicare, and Medicaid came to $26.3 billion. The Federal government as a provider and purchaser of health care is in a position to provide major assistance and leadership in the development of injury-prevention and patient-safety programs.

The Commission RECOMMENDS Federal sponsorship of research and demonstration programs to assist in carrying out the necessary investigations in order to develop the recommended injury-prevention programs. The Federal government should also support the development of a nationwide system for the continuous monitoring and evaluation of medical injury-prevention measures, in order to assure the cross-fertilization of new techniques and approaches between and among all categories of health-care providers.

Chapter 6

The Human Dimension

A malpractice suit reflects not only a patient's dissatisfaction with the result of treatment, but frequently it is an expression of anger by the patient directed towards the doctor who treated him, the hospital in which the treatment was provided, or both. What prompts such anger? What factors in the treatment process seem to give rise to the greatest frustration and disappointment, and how can they be prevented?

The importance of human relations in the malpractice problem has been recognized by nearly everyone who has attempted to analyze the cause of malpractice litigation. In fact, there are those who believe the malpractice problem is essentially a human relations problem, and that greater attention to the human component is the only sure solution.

We discuss in this chapter some of the interpersonal factors which contribute to the malpractice problem, beginning with the quality of physician-patient, nurse-patient, and hospital-patient relationships. Later, we discuss the rights of patients undergoing treatment and the special problem of medical research using human subjects. Finally, we discuss the role of health care consumers in helping to ameliorate the malpractice problem.

The Human Component of Patient Care

The quality of the relationship between the patient on the one hand and the doctor or hospital on the other may stimulate the patient either toward or away from filing a malpractice suit. In plain truth, the suit itself is often merely tangible proof of the final breakdown of that relationship.

"If understanding between physician and patient is not commensurate with the necessary diagnostic and therapeutic activities, there is a strong possibility of a failure of treatment, the collapse of the relationship, or both. If both occur at about the same time, chances for a lawsuit are strong."[1]

Doctors themselves are acutely aware of this problem. Indeed, of physicians who responded to a questionnaire sent out by a professional magazine, 37% of 420 who had been sued or threatened with suit and 44% of 448 who had not been sued or

[1] Louisell & Williams, *Medical Malpractice*, Matthew Bender & Co., New York, Sec. 5.02, Page 137.

threatened named "poor communication between physician and patient" as the single most common cause of malpractice suits.[2] In third place as the most common cause was "declining public regard for doctors" named by 14% of the physicians who had been sued or threatened and by 11% of those who had not. That decline, if it actually exists, may simply be another result of poor communication.

Much of this lack of rapport or failure of communication may be inherent in the personalities of the principal parties involved. A 1957 study on the human relations aspects of malpractice litigation discussed at some length the characteristics of suit-prone patients and suit-prone physicians.[3] The suit-prone patient was found to be a person who goes into a medical situation with a variety of unrealistic attitudes, including unreasonable beliefs about money ("the doctor should be paid only when he produces quick results"), about physicians ("I don't trust them; they can't really help me"), and about medicine ("everything should be curable"). In addition, he tends to be dogmatic and quick to blame others when things go wrong.

The study characterized the suit-prone physician as one who cannot admit to himself his own limitations of training and experience, and who, when confronted by a dissatisfied patient, often responds to the situation by neglecting the patient or by dismissing his complaints as trivial. Instead of finding out how to make the patient feel less angry, less afraid, or less depressed, he is more preoccupied with his own image. More often than not, he tends to regard the patient as a symbol of his own failure, and unconsciously punishes him by an indifference which amounts to rejection. In so doing he completely distorts the physician-patient relationship to satisfy his own psychological needs.

Given a suit-prone patient, even the most competent of physicians may become the target of the patient's desire for revenge. If the physician happens to be one who has many of the psychological traits just described, the chances of a malpractice suit resulting are increased immeasurably. Similarly, a breakdown in rapport between the patient and other health-care personnel can trigger malpractice suits.

Of course many suits are brought by patients who are not suit-prone against doctors who are not suit-prone either, but it is clear to the Commission that the human element is an important aspect of the malpractice problem. It is not suggested here that a smiling, wise physician can or should beguile an injured patient out of filing a meritorious claim nor, at the other extreme, that a long-suffering patient should do nothing when he is clearly the victim of negligence in treatment. However, we do believe educating patients as to what they reasonably can expect from medical treatment and educating providers in ways of enhancing communications and rapport can help reduce tensions and the number of malpractice suits by making it easier for patients and providers to use other avenues for reconciling their differences.

Remedial steps for dealing with these problems will not be easy to take, but the Commission believes that an attempt must be made. Action should be taken at all levels, beginning with the education or training of the provider. We, as a Commission, believe that medical, dental and nursing schools should deal with this human relations element as well as teaching the science of medicine.

Some Commission members were reluctant to outline course content or to recommend that schools add courses to already crowded curricula—particularly in view of the trend toward the shortening of medical education. However, the majority felt that examples of such courses would be helpful.

This type of education should not stop at the conclusion of formal education. The Commission believes that the human element should continue to be emphasized both in postgraduate education and throughout the health-care provider's career.

The Commission FINDS that physician-patient, nurse-patient and hospital-patient relationships exercise a significant influence on the diagnosis and treatment of illness. Effective management of these relationships is an integral

[2] *Medical Opinion*, December, 1971.

[3] Blum, R. H.,: *The Psychology of Malpractice Suits*, California Medical Association, San Francisco, 1957.

part of patient care and has a direct bearing on the overall quality of care.

There is a general need for more effective communication between physician and patient. There is a particular need for frank and full discussion of the diagnosis, prognosis and proposed course of treatment, and no less so of the complications and other adverse results of treatment, since these are the events which have the greatest potential for malpractice litigation.

The Commission RECOMMENDS that all medical, dental and nursing schools develop and require participation in programs which integrate training in the psychological and psychosocial aspects of patient care with the physical and biological sciences.

Illustration: Undergraduate courses of study should include not only the behavioral sciences, but courses in the history and philosophy of medicine, medical ethics, human values and relationships, and the social structure of health care institutions. Greater attention should be given to teaching the art of medicine, both in the classroom and in making rounds. Professors on rounds should epitomize professional humane practice and should insist on similar conduct from their students.

Everyone Participates

It is not only doctors, dentists and nurses who come into contact with patients and who influence their attitudes and feelings toward the care they receive. Nurses, aides, and orderlies, admitting clerk and cashier, administrator and porter, all have the potential for making the patient feel better or worse. All should have an understanding of human relations, especially as they concern sick and worried people.

The Commission RECOMMENDS that all categories of health-care personnel receive training in order to develop attitudes and skills in the interpersonal aspects of patient care. This training should utilize the most advanced educational technology and should be included in postgraduate and continuing education programs as well as throughout the entire period of undergraduate training.

Talking About the Patient

Doctors meet regularly in hospital staff conferences to discuss medical problems. Tissue committees talk over pathology findings, utilization review committees discuss length of stay and the propriety of admissions, clinical seminars may be held to discuss a particularly unique disease, diagnosis or treatment, and departmental meetings may hear a distinguished visitor describe the latest treatment for a certain condition. But seldom, if ever, do medical staff members meet to discuss the psychological aspects of their patients' problems, unless those problems are so severe that psychiatric services are required. Even then psychiatrists, psychologists and social workers generally discuss only those aspects of the patient that concerns them. Rarely is the whole person an object of concern.

The Commission RECOMMENDS that staff conferences be expanded to include discussion of the ethical, social and psychological aspects of patient care, and that periodic faculty-student seminars be devoted exclusively to discussion of these matters.

Frustrations of the Hospital

Even under the best of circumstances, being in the hospital tends to make a patient unhappy. He is thrust into a strange world where even the smallest and most intimate details of his existence, are dictated by strangers. His clothing is taken away and replaced by an awkward hospital gown; he has no privacy or control over what is done to him. His visitors are limited. He may be awakened in the middle of the night by a nurse who wants to take his temperature. Such circumstances tend to magnify the patient's reaction to any dissatisfaction with his medical treatment.

The Commission believes that traditional hospital procedures that add to the discomfort or unhappiness of the patient—particularly those that exist solely on the grounds of efficiency and are not medically required—should be modified or eliminated. More attention should be paid to alleviating the fears and anxieties of patients. Special attention should be devoted to the psy-

chological and emotional needs of children who are in the hospital and to the needs of their parents.

In the final analysis, methods for alleviating patient dissatisfaction should follow the commonsense principle of providing the best physical and emotional care for all patients.

The Commission FINDS that improving the human and environmental aspects of patient care can enhance therapeutic outcomes, increase patient satisfaction, and reduce the stimuli to malpractice litigation.

The Commission RECOMMENDS that improvements be made in the physical environment and methods of management of hospitals and other health care facilities to assure greater attention to the psychological and psychosocial needs of patients.

Note: The rights of patients to be treated with dignity and respect, a topic covered later in this chapter, are equally pertinent in this context. The autonomy of the patient should be maintained as much as possible; he should be accorded the common courtesies expected in society; he should be encouraged to participate in the treatment process. Rehabilitation of the patient should begin the day of entry into the hospital. Barriers to rehabilitation should be modified or eliminated to accelerate restoration of health. Restrictions on patients' activities deemed necessary solely for institutional efficiency should be eliminated.

Great Expectations

As noted earlier, great advances have been made in medical care and the newspapers, radio and television have given growing attention to these advances. Without question, the broadcasting media have found that medical science has entertainment value. Series about both the modern medical center and the kindly, wise family doctor are sure favorites with the viewing public.

Unfortunately, in translating complex, technical medical information for the general public, the media often tend to oversimplify. This, in turn, leads to unrealistic expectations about the capabilities of medicine and physicians. This popular treatment of medicine tends to emphasize dramatic accomplishments, while giving short shrift to the risks or limitations of new drugs or surgical procedures. In addition, publicity about scientific research frequently leads the public to believe that "miracle" cures are available when, in fact, the proposed treatment is still in the investigatory stage.

This type of publicity has led some patients to believe that physicians can cure any disease, save the life and health of any patient, and correct any kind of physical defect. The majority of patients are not this misinformed or unrealistic, but when the results of treatment are unsatisfactory, some patients blame the doctor even though he may have given the best possible medical care under the circumstances.

The Commission urges that medical and health education for the public no longer be left to chance. Special programs should be developed aimed at educating the public on a wide variety of health-related matters.

The Commission FINDS that the expectations of patients concerning the technical capabilities of medicine are often exaggerated and unrealistic. There is a need to educate all patients concerning the hazards, risks, costs and limitations of medicine, in order to reduce disappointment, frustration, and dissatisfaction with the outcome of treatment.

These exaggerated and unrealistic expectations of patients are often the result of myths and false information conveyed by the media.

The Commission RECOMMENDS that special programs be developed to educate the public on health care subjects about which patient knowledge is deficient, and which may contribute to later malpractice litigation. These subjects include: health and hygiene (including the origins of disease, function of body organs, nutrition needs, etc.); how to communicate with health care personnel; the economics of medical care; the conventions of medical practice (e.g. consultation, referrals, use of surgical assistants, etc.); and the limitations of medical science.

Psychological Needs of Patients

Some research is currently being conducted on the psychological needs of patients and how to accommodate them. The Commission believes that both the private and the public sectors should support further studies in this area. This research should be directed toward a variety of problems, ranging from improving health-provider education in human relations to improving the physical design of institutions.

The Commission RECOMMENDS continuing programs of research and analysis aimed at increasing knowledge and understanding of patients' psychological and psychosocial needs and that findings of such research be translated into specific action programs, aimed at improving the physical design and methods of management of health-care facilities and at improving the training of health-care personnel in the human relations aspects of patient care.

Patients' Rights

An important aspect of the human dimension of the patient-provider relationship concerns the rights of patients as human beings. The failure to recognize these rights can either aggravate an already sensitive relationship or create fertile ground for future affronts which may lead to a malpractice suit.

A hospital can be a very intimidating place to many people. Being in the hands of strangers at a time of sickness, being in a strange world where many mysterious things are happening, having people do often incomprehensible things to one's body—these and other factors can make a person frightened enough to be easily imposed upon. At the same time, a rushed and harrassed hospital staff may all too often ignore the feelings of the patient in the interests of hospital efficiency and speed.

But every patient is an individual who is entitled to certain fundamental rights. Among these is the right to simple courtesy, for example, the right to be addressed by unfamiliar people as Mr. and Mrs. Soandso, rather than as John or Mary. He has the right to privacy, to be at least curtained off from public view while undergoing treatment. He has the right to communicate his problems in his own language, where that is possible. He also has the right to be told what is wrong with him and to an explanation of the type of treatment that is to be given.

The Commission believes that to ignore these and other rights of the patient is both to betray simple humanity and to invite dissatisfaction that may lead to malpractice suits. The Joint Commission on Accreditation of Hospitals includes in its current accreditation manual a statement of patients' rights which are to be observed by accredited hospitals. The American Hospital Association recently has adopted a similar statement. We note with satisfaction that some hospitals are printing clear, simple written statements of patients' rights in leaflets that are given to patients upon admission. Often these leaflets are printed in other languages as well as English when the number of the hospital's patients speaking other languages justifies this procedure. The Commission strongly believes that this practice should be encouraged and the rights of all patients fully protected.

The Commission RECOMMENDS that hospitals and other health care facilities adopt and distribute statements of patients' rights in a manner which most effectively communicates these rights to all incoming patients.

Two such statements were brought to the Commission's attention, one distributed by Boston's Beth Israel Hospital, and the other by the Hough-Norwood Family Health Center in Cleveland. The Commission believes that these statements set forth the minimum rights that should be accorded all patients.

Your Rights As A Patient At Beth Israel Hospital, Boston

Beth Israel Hospital, its doctors, nurses and entire staff are committed to assure you excellent care as our patient. It has always been our policy to respect your individuality and your dignity. This listing is published to be certain that you know of the long-standing rights that are yours as a Beth Israel patient.

1. You have the right to the best care medically indicated for your problem, that is, to the most appropriate treatment available without considerations such as race, color, religion, national origin or the source of payment for your care.

2. You have the right to be treated respectfully by others; to be addressed by your proper name and without undue familiarity; to be listened to when you have a question or desire more information and to receive an appropriate and helpful response.

3. You have the right to expect that your individuality will be respected and that differences in cultural and educational background will be taken into account.

4. You have the right to privacy. In the clinics, you should be able to talk with your doctor, nurse, other health worker or an administrative officer in private, and know that the information you supply will not be overheard nor given to others without your permission. In the Hospital, when you are in a semi-private room, you can expect a reasonable attempt to keep the conversation private. When you are examined, you are entitled to privacy—to have the curtains drawn, to know what role any observer may have in your care, to have any observers unrelated to your care leave if you so request. If you are hospitalized, no outsiders can see you without your permission. Your hospital records are private as well, and no person or agency beyond those caring for you can learn the information in your medical record without your specific permission.

5. You have the right to know the name of the doctor who is responsible for your care; to talk with that doctor and any others who give you care; to receive all the information necessary for you to understand your medical problems, the planned course of treatment (including a full explanation about each day's procedures and tests) and the prognosis or medical outlook for your future; to receive adequate instruction in self-care, prevention of disability and maintenance of health. You have the right to ask the doctor any questions that concern you about your health. You have the right to know who will perform a test or an operation, and the right to refuse it. Because this is a university hospital, you may come across doctors, nurses and other health workers in training, or you may be asked to participate in special studies. We believe that the presence of students adds to the quality of care. Nevertheless, you have the right to have a full explanation of any research study or any training program for students before you agree to participate in it, and the right to refuse to participate. If you agree to the diagnostic and therapeutic procedures recommended by your doctor, you may be asked to sign a consent form, but if you refuse, you have the right to receive the best help that the Hospital can still offer under the circumstances.

6. You have the right to leave the Hospital even if your doctors advise against it, unless you have certain infectious diseases which may influence the health of others, or if you are incapable of maintaining your own safety, as defined by law. If you do decide to leave before the doctors advise, the Hospital will not be responsible for any harm that this may cause you and you will be asked to sign a "Discharge Against Advice" form.

7. You have the right to inquire about the possibility of financial aid to help in the payment of your Hospital bills and the right to receive information and assistance in securing such aid.

Patients also have certain responsibilities which should be carried out in their own best interests:

Please keep appointments, or telephone the Hospital when you cannot keep a scheduled appointment; bring with you information about past illnesses, hospitalizations, medications and other matters relating to your health; be open and honest with us about instructions you receive concerning your health, that is, let us know immediately if you do not understand them or if you feel that the instructions are such that you cannot follow them.

You have the responsibility to be considerate of other patients, and to see that your visitors are considerate as well, particularly with reference to noise and smoking, which are usually very annoying to nearby patients.

You also have a responsibility to be prompt about payment of Hospital bills, to provide information necessary for insurance processing of your bills, and to be prompt about asking any questions you may have concerning your bills.

Beth Israel Hospital is interested in keeping you in the best health possible. If you feel you are not being treated fairly or properly, you have the right to discuss this with your doctor, nurse, unit manager, other health worker, or the Administrator-on-Call. You may also write a letter the the General Director, Beth Israel Hospital, Boston 02215. All correspondence will receive prompt and personal attention.

This message reflects the interest and philosophy of the entire staff of Beth Israel Hospital.

Hough-Norwood Family Health Center, Cleveland

Patients' Rights

1. You have a right to know what's going on. Always ask questions about anything that you do not understand or that is worrying you.

2. If you think you have been waiting too long for service, ask at the front reception desk and they will find out the reason for the wait and help you to be served as soon as possible.

3. You should be called Mr., Mrs., or Miss unless you have given a staff member permission to call you by your first name.

4. You have a right to consent to or refuse any treatment for yourself or your child.

5. You have a right to have things explained

clearly. For example, Health Center procedures and possible side effects of medicines.

6. You have the right to know the procedure for changing physicians and dentists. Ask for the Medical or the Dental Director.

7. You have the right to expect our staff members to display the highest regard for your privacy.

A. No employee should talk to you about your problems in the waiting room or halls where others may hear.

B. No one should call across the room for personal information. For example, "Do you have Medicare" etc.

C. You have a right to consent to any visit to your home. If anyone from the Center visits you at a time you don't want to see him, tell him if and when you would like him to return.

D. You have the right to refuse to participate in or be interviewed for research purposes. You have the right to full explanation of purposes and uses of the information if you do participate.

8. You have a right to choose a convenient time and day for your appointment, if it is available. You should be told what times are available.

9. You should be notified in advance whenever possible when your physician cannot keep an appointment.

10. If you are too sick to walk or take a bus, you can request transportation to and from the Health Center. Ask the staff member who is working with you to arrange transportation. If you decide not to use the transportation system, please call and cancel your transportation.

11. You can receive help in applying for social services. Ask your physician to refer you to the Department of Social Services.

12. If a delay is expected in getting your medicines or certain tests (such as an EKG) you have the right to know and to request to return some other time if possible.

Patients' Responsibilities:

1. Patients should keep appointments. If you cannot keep an appointment, call the appointment section as early as possible so that another patient may be scheduled in your place.

2. Patients that cannot keep appointments at referral centers (e.g. to see a specialist or have special X-rays done) should call the Center and cancel the appointment so another patient may have that time.

3. The patient should bring with him to the Health Center the name and address of other physicians that he has been seeing, or the cards of any clinic he has attended, including your Hough-Norwood card. This will enable the Health Center staff to send for old records that may help give you better health care.

4. You should be frank about medical instructions of the Center staff. If for any reason you feel you cannot or should not follow recommendations, talk to the staff member right away.

5. You should bring your children's immunization records when you bring them to see their doctors.

6. Patients should inform the record room about new addresses, telephone numbers, change of names as soon as possible to prevent loss of appointments and to be able to reach patients in serious situations.

Patients In Teaching Hospitals

Special problems arise with respect to patients in teaching hospitals.

Historically, medical students learned their clinical skills by observing, and young doctors learned by practicing, on hospital patients who were provided free care in return. Today, the "charity patient" has almost disappeared. In most cases private health insurance, Medicare, and Medicaid have wiped out the economic distinction between poor patients who are treated primarily by medical students, and paying patients whose care is supervised by their own physicians. The elimination of the distinction between paying and non-paying patients has emphasized the need that health-care providers, especially teaching hospitals, do away with all unnecessary distinctions between patients based solely on their ability to pay for health services.

Generally, the sole purpose of medical care is to help the patient get well. The teaching hospital, however, has two other purposes as well: to train the oncoming generation of physicians, and to advance medical knowledge through research. Unless great care is exercised, the last two factors can sometimes result in misunderstandings and dissatisfied patients, thus heightening the potential for malpractice litigation, even though the quality of care rendered in teaching hospitals is widely considered to be excellent.

More and more teaching hospitals are coming to regard all patients, poor and affluent alike, as teaching patients, as some have done for many years. The nature of the institution is explained to the incoming patient, who is told why his attending doctor will be accompanied by several young doctors when he comes to the bedside. The patient

is informed that his care will not be rendered by his attending physician alone, but by the team of which his doctor is the chief.

Old traditions die hard. Many patients do not understand the functions of a teaching hospital and fear that they will be treated by clumsy beginners or used as unwitting and unwilling subjects for some sort of medical research. Therefore, the patient who is about to enter such an institution should be told fully what to expect, that he will receive quality care and that, at small inconvenience, if indeed any at all, he will also be making a contribution to the common good of all future patients. His own doctor should tell him in advance that he is expected to cooperate with the teaching program and assure him that he will not be left to the mercy of the unskilled. He should also be advised that he will not be a subject for medical research without his full knowledge and consent. Upon admission, he should be given a statement explaining the educational aims and activities of the institution and told how students, interns and residents will participate in his care. The Commission recognized that some teaching hospitals are already doing this. We believe that all should adopt these principles as standard guidelines for ethical conduct.

The Commission RECOMMENDS that the functions of teaching hospitals be explained to all patients entering such hospitals, and that these functions be emphasized in other forms of consumer education.

The Commission RECOMMENDS that, where they exist, distinctions in the treatment of patients in teaching hospitals based on the patient's race or socioeconomic status be eliminated.

Informing the Patient

Apart from the legal aspects of the doctrine of informed consent, the patient has a right to know what is happening or will happen to his body, and to participate in decisions about it. A patient who wants the information should be fully informed of the pros and cons of a proposed treatment or procedure. He is entitled to know both the benefits that may be hoped for and the dangers involved, since only in the light of such knowledge can he fairly decide whether or not he wants to undergo the proposed treatment. He also has a right to know what the consequences are likely to be if he refuses the proposed treatment.

The Commission believes that in many instances genuine misunderstanding exists on one or both sides. The doctor may believe that he has fully explained all ramifications to the patient, but the patient may not have understood much of what was said. The patient may be fearful of asking questions and the doctor may not recognize his timidity. The patient may be so dazzled by his hopes that his mind turns off the warnings.

Nevertheless, since it is the patient's body or his life that is at risk, we believe that he has the right to know, to the extent possible, what the risks are. It is the physician's duty to translate technical terms into language the patient can understand so that complete communication can in fact be achieved.

The Commission FINDS that there is a generally-recognized right of a patient to be told about the danger inherent in proposed medical treatment. That right is consistent with the nature of the doctor-patient relationship and with fundamental fairness. A much greater degree of communication between health-care providers and patients is really good, basic medical practice and should be encouraged.

The Need For A Uniform Standard

The legal system study we commissioned shows that, at least on the appellate level, informed consent presently is not a major factor in malpractice cases.[4] The Commission understands, however, that the number of cases in which the doctrine is pleaded at the trial level has grown enormously within the past several years, and the Commission's Legal Issues Advisory Panel was of the opinion that its importance will continue to grow.

Because of the doctrine's relative newness, there are differences of opinion and confusion concern-

[4] *Legal System Study*, Westat, Inc., APPENDIX.

ing its application among the courts, and the law is in a state of flux. We believe that a uniform standard of disclosure would be helpful to the courts, the health providers and the public. Our earlier recommendation concerning the legal aspects of this matter appears in Chapter 4.

We perceive another possible problem: medicine today increasingly is being practiced not by one physician with one patient, but by teams of physicians and others. In such situations, multiple decisions may be required from several people. Should each of the providers involved in the chain of treatment of one episode obtain a separate informed consent from the patient? We do not know to what extent this is presently a problem, but we believe the situation should be watched as medicine comes more and more to rely upon team care.

Whatever the answers to these questions, uniform standards would go far toward giving both patients and physicians more understanding of where they stand in relation to the law.

The Commission FINDS that the law relating to the nature of information which the health-care provider must supply to obtain valid consent for treatment is presently in flux. Adoption of uniform standards requiring full disclosure of material risks would eliminate much confusion as to the basis and nature of informed consent. Under such standards, both patient and doctor would gain a clearer understanding of their respective rights and obligations.

The Dilemma of Full Disclosure

It is difficult to determine the point beyond which the full catalog of risks would frighten patients and result in their refusing treatment even where the potential benefit would far outweigh the risk. It is also difficult to assess how much information can be transmitted without also creating such apprehension about possible side effects that even though treatment is accepted, recovery is hindered. Unquestionably, in some instances, informing the patient completely would do more harm than good. However, both for the patient's well-being and the doctor's legal protection, at least some responsible person who is close to the patient should be fully informed and should help make the decision of whether or not to undergo treatment.

The Commission RECOMMENDS that a responsible member of the patient's family be given appropriate explanations where the physician is justifiably reluctant to explain such matters directly to the patient because of his concern that the explanation itself is likely to affect the patient adversely.

Access To Medical Records[5]

One of the most hotly debated issues before the Commission was over the mechanics of the access of a patient to his hospital or physician medical record. The Commission was in agreement as to the basic right of the patient to know the nature and detail of his diagnosis and care. However, there was not unanimous agreement as to a right of unrestricted access to the medical record at the hospital or the physician's office. Although we agreed that neither the hospital nor the physician had the right to cover up, we differed with respect to what was in the best interest of the patient and his ultimate care.

The Commission ordered a study which indicated that in 41 states, if denied access to his medical records, the patient must resort to court action.[6] In the other nine states a variety of statutes have made the records available without resort to litigation.

The Commission recognized that the absolute refusal by the hospital or the physician to make the medical record available to the patient may, in itself, lead to unwarranted suspicion and possibly trigger a malpractice suit to gain access to the record.

The Commission FINDS that the unavailability of medical records without resort to litigation creates needless expense and increases the incidence of unnecessary malpractice litigation.

[5] See Dissenting Statement by Norma Almanza.

[6] *Access to Medical Records,* Georgetown Law Center, APPENDIX.

The Patient's Right to Medical Information

We believe that the patient has a right to the information contained in his medical record—whether that be the hospital record or his doctor's office record.

The majority of the Commission pointed out that a medical record in the hospital or the physician's office is far more than a series of entries reporting diagnoses, doctor's orders and actions taken pursuant to such orders. In the hospital setting the record is a complex of communications between health professionals, including a written history and physical, progress notes, nurses' notes, consultations, lab reports, operation summary, discharge summary, and the like. During the course of a particular hospitalization the record may include a wide spectrum of speculation and observation as the various members of the health team contribute thoughts and observations that lead eventually to the final diagnosis. If not properly explained, many of these entries could be exceedingly disturbing to a patient already apprehensive. However, to deter such entries could often eliminate the very clues that lead to successful diagnosis and treatment.

It is good medical practice for the attending physician to require such tests or diagnostic steps as may be necessary to exclude the possibility of cancer, even if remote, but the very suggestion of such possibility to many patients might adversely affect their path to recovery. Also, the health teams use a wide variety of abbreviations and phrases that can be both confusing and unintelligible to the layman. For all of these reasons, the patient, though he is entitled to information about his health and his care, needs guidance in understanding and using it. For reasons such as these, many physicians are reluctant to give copies of their records to patients. However, in a malpractice suit the records will be turned over for the patient's lawyer or medical witnesses to interpret as they will. The question, as we see it, is whether the patient should have to go to the extreme of filing suit to gain access to them.

Because of these complexities, we differed among ourselves on the point of whether the patient's "right to know" should be completely unrestricted or whether it should have legal safeguards built around it. California provides that, although the patient does not have the right to direct access to the records, he may authorize his legal representative to examine and copy all or any part of the record without the necessity of filing suit. The rationale of this approach is that, although the hospital or physician could and would release the record directly to the patient in many situations, if there is doubt as to such release being in the best interest of the patient, then intervention of his legal representative would create an effective screening mechanism to assure proper communication and explanation.

Access through an attorney has much to recommend it, but the poor often have difficulty in obtaining legal services.[7] We agree that they should not be excluded from access to their records simply because they cannot get a lawyer to represent them. In some areas, legal aid groups are empowered to handle such cases, but in other areas they may be prohibited from working on any matter that could be fee-producing.

We believe there are techniques to deal with this restriction. For example, in Pittsburgh potentially fee-producing cases are referred to attorneys who will undertake the initial representation of clients for nominal fees, such as five or ten dollars. Such mechanisms, however, can be worked out only on a local level. We believe communities should make arrangements that would allow attorneys to represent indigent patients in gaining access to their medical records.

Among the nine states that allow patients access to their medical records without having to go to court, the statutes vary greatly:

- California, Illinois and Utah permit records to be examined and copied by the patient's attorney. The patient does not have the right to direct access.
- Massachusetts, New Jersey and Wisconsin explicitly or implicitly allow direct access to the patient himself.
- Mississippi requires a showing of good cause.
- Connecticut permits records to be examined only after the patient has been discharged from care.

[7] See our recommendation regarding legal assistance in Chapter 4.

We believe that some sort of uniformity must be brought into this area. At present records are not uniformly available, and there are differences in method in states which do not have appropriate statutes.

The Commission FINDS that patients have a right to the information contained in their medical records and RECOMMENDS that such information be made more easily accessible to patients, and the Commission further RECOMMENDS that the States enact legislation enabling patients to obtain access to the information contained in their medical records through their legal representatives, public or private, without having to file a suit.

A related problem area was brought to our attention during our public hearings. We were told of cases where it was proved that medical records had been altered to protect the hospital or the provider. We find this intolerable.

The Commission RECOMMENDS that the states enact legislation to prohibit modification, alteration or destruction of medical records with the intent of misleading or misinforming patients.

Medical Research Involving Human Beings

An area of special concern to the Commission and one which we dealt with at some length, relates to the use of human beings in medical research. It is, to be sure, an aspect of patients' rights. Beyond the rights of individual patients, however, we see a broader need for guaranteeing the highest degree of ethical conduct in the carrying out of all such research, for the good of the general public. We firmly believe that protection of the rights and health of patients who participate in medical research is of vital importance. We also believe, however, that safeguards which are created must not stifle research so that future generations are deprived of possible benefits.

Medical research necessarily involves some hazards for the patients or subjects who participate in the research. Despite prior testing with laboratory animals, the value and risks of a new medical procedure cannot ultimately be determined without testing it on human beings.

Although continuing medical research is essential for public welfare, the public good does not justify exposing individual patients to unwarranted risks. Moreover, no patient should be subjected to risks against his will. Guidelines for carrying out clinical research have been in existence for years.

The Commission believes that the World Medical Association's Declaration of Helsinki, and the Ethical Guidelines for Clinical Investigation adopted in 1966 by the Judicial Council of the American Medical Association represent effective standards for protecting the interest and welfare of individual patients or subjects without unduly hampering medical research.

The Commission RECOMMENDS that physicians engaged in clinical research consider as minimum standards of ethical conduct the World Medical Association's Declaration of Helsinki and the American Medical Association Guidelines for Clinical Investigation.

Those Who Are Not Legally Competent

At times, medical research is oriented toward a particular class of patients, e.g. children, or the mentally retarded. The Commission believes that such research is vital and should be encouraged—under appropriate standards and guidelines—particularly in the pediatric age group, to assure the adequacy of therapeutic means for treating children.

We recognize, however, that there are special problems involved in medical research using children or adults who are not legally capable of giving an informed consent. It is important that the rights of both be protected. Important though it be that the search for new and better forms of therapy continue, there must be a careful balancing of interests and we believe that special measures should be employed to protect the rights of such persons.

The Commission RECOMMENDS that where clinical investigation necessarily involves the

participation of persons who are not legally competent to give valid consent, extraordinary precautions be established to protect the interest of such persons.

The Commission believes that the best guarantee of ethical standards of conduct in experimental medicine lies in the mental attitudes and prevailing values of the community of medical researchers. The competition for discovery and recognition by one's peers must not lead to unduly permissive behavior in the use of human subjects but must always operate within the framework of the medical profession's fundamental ideal: the relief of human suffering. These principles should be stressed throughout the period of training of all research scientists.

The Commission RECOMMENDS that the biomedical research community make every effort to educate its prospective members in the fundamental principles of research ethics.

Federal Guidelines

In 1966, the Public Health Service (Department of Health, Education, and Welfare) began requiring all institutions applying for PHS funds for research to meet certain requirements. Since that time, it has been mandatory that all such proposals be reviewed by a committee within the research institution to determine that the rights and welfare of the persons involved are adequately protected, that the risks to an individual are outweighed by the potential benefits to him or by the importance of the knowledge to be gained, and that informed consent is obtained by adequate and appropriate methods. This review must be completed before the award of any PHS grant or contract that involves experimentation with human subjects. In addition, the committee must establish continuing review of the project.

Proposals are reviewed further by government advisory committees. If the proposal raises issues of undue hazards to human subjects, or, rarely, of clearly ethical issues, these are called to the attention of the institution that made the proposal.

The 1966 Public Health Service Policy on the Protection of Human Subjects, now extended to cover all research funded by the Department of Health, Education, and Welfare, has been modified and expanded in the light of cumulative experience. We believe there is still room for improvement, especially in the implementation of the policy.

Although the Food and Drug Administration does not sponsor a large amount of research, it does have direct regulatory authority over the pre-market testing of new drugs on the part of the drug industry. In 1971 the FDA began requiring local committee review of drug tests. Its guidelines are identical to those used by PHS, but have the added requirement that the committees must include persons who are not scientists, such as lawyers, clergymen or other laymen.

There have been objections raised over the use in investigational medicine of subjects whose freedom to consent is questionable by reason of infancy, senility, mental retardation, ignorance or legal confinement. On the other hand, the medical care given these subjects is usually excellent, and often otherwise unavailable to them. Prisoners who volunteer as experimental subjects acquire a sense of personal worth and pride as well as material advantages.

The FDA requires that researchers testing new drugs agree to comply with the applicable HEW research policy. Here again, surveillance of actual compliance presents difficulties. In a 1969 test of the side-effects of contraceptive pills in San Antonio, Texas a group of women coming regularly to a clinic were, without their knowledge, given nothing but placebos. The researcher responsible for the San Antonio experiment is now conducting experiments in Latin America with a $900,000 grant from the Agency for International Development. Written assurance of compliance with Department of Health, Education, and Welfare policy has been given. But, again, there is no monitoring of actual performance.

The Department of Defense conducts most of its research at large military installations. Conscientious objectors, paid volunteers and active-duty military volunteers are used as subjects. The Department also conducts clinical investigations in teaching hospitals. Many initial trials are done by the researchers on themselves.

The Veterans Administration conducts an extensive program of medical research in the VA hospitals. The Department of State's Agency for International Development funds research involving human subjects both at home and abroad. Both the VA and AID have adopted the HEW Policy on the Protection of Human Subjects.

The Commission believes that the HEW requirements should be applied to all medical research involving humans, whether done by the private sector or government agencies, and whatever the source of funding.

As a practical matter, this is already usually done—at least in the private sector. It is too complicated for institutions that receive HEW research funding to establish two different standards for developing studies. The custom that most institutions follow is to subject all research to the review committees required by HEW. The Commission urges that this practice be adopted by all universities and research organizations.

The Commission RECOMMENDS that the Department of Health, Education, and Welfare Guidelines on medical research involving humans be applied to all persons participating in medical research regardless of the source of funds which support the investigation.

Compensation For Injured Research Subjects

Many persons who participate in medical research are healthy volunteers. Some others are patients who volunteer for tests of a drug or other therapy that will have no effect on their diseases. The Commission is concerned about compensation for such volunteers if they are injured in the course of treatment.

In the case of research conducted by the Federal Government, volunteers who are injured during experimental treatment are given free and continuing medical care. However, no additional compensation is paid unless the volunteer can prove negligence on the part of the investigator. The Commission believes that persons who volunteer to be research subjects should be entitled to compensation for injuries sustained as a *direct* result of the experimental treatment, whether or not due to negligence.

In the case of Federally-supported research, the Commission believes that funds for this purpose should be included in the basic grant. Moreover, the same rules should apply whether the Federal Government supports research or whether research is funded solely by the private sector.

The Commission RECOMMENDS that whenever a grant or other funding is provided by the Federal Government for medical research involving human subjects, the grant should include a sum sufficient to provide either insurance or a self-insurance fund in order to provide compensation to any human subject who may be injured in the course of the research. Where the Federal Government itself conducts the research, precisely the same rules should apply, either through the Federal Employees' Compensation Act or other Federal funding sources.

The Commission RECOMMENDS that whenever research involving human subjects is conducted by the private sector that insurance be provided to protect against mishaps, injury or illness directly arising out of that research.

Consumer Participation In Health Care Decision-Making

The preceding sections of this chapter have looked at provider-patient relations and various aspects of an individual patient's right to be informed concerning the nature and progress of his medical treatment. Patients are also consumers who have a unique knowledge of their health care needs and of the ways these needs should be met. Their participation in making the decisions which affect the delivery of health has the potential to improve both the quality of health care and their satisfaction with the health-care system.

Today an increasing percentage of the nation's health care is being provided through neighborhood health clinics, Health Maintenance Organizations, and the outpatient departments of hospitals. This institutionalized medicine tends to be far more impersonal than the care provided by the familiar family doctor, and many patients feel unable to make their needs and complaints effec-

tively known in these settings. Although many institutions providing medical care are governed by boards comprised primarily of laymen, these people are usually not chosen because they represent any particular group of patients. Rather, they tend to be persons who are prominent business, religious, governmental or social leaders of the community. While many trustees (if not most) are civic-minded individuals with a real interest in the role and responsibility of the hospital to the community at large, they are not typically representative of a cross-section of the community.

Consumer participation in health care services has grown out of the efforts of recipients of health care to influence the institutions providing health care to them. A variety of methods for consumer participation have been tried. They range from the patient advocate to persons who represent patients on hospital governing boards. By making patients, potential patients, or their advocates an integral part of the health care decision-making process, the patient's viewpoint is reflected in health care policy decisions aimed at improving the quality of care and increasing patient satisfaction. Better care and satisfied patients can go a long way toward reducing both actual malpractice and malpractice claims and suits not involving malpractice.

In recent years consumer participation in health care planning and delivery has been a goal of many consumers from diverse economic and social backgrounds. The demands of patients for a greater voice in the planning and delivery of their health care has been fostered by two factors. One, increasing dissatisfaction with the current system has caused many patients to believe that the health-care system should be changed and that consumers of health care should participate in making the changes. Two, the acceptance of consumer participation has been aided by the realization that many decisions involving health-care delivery do not require highly technical medical knowledge, but instead a knowledge of community wants and needs.

Advocates of consumer participation argue that health-care recipients should have a place in health-care planning because health care has an incalculable effect on consumers' lives, and because patients pay the bills, directly or indirectly, through taxes or insurance. Consumers also have unique knowledge to contribute to the decision-making process. In turn, they learn more about the health-care system through their participation. The education of consumers increases the effectiveness of their participation and helps to make their expectations of the health-care system more realistic.

The mechanisms for consumer participation vary greatly. The success or failure in a particular situation, measured by increased patient satisfaction and improved quality of care, is linked more closely with the degree of control exercised by the consumers than with the particular method of participation. Where consumer participation has been meaningful, the result has been both greater satisfaction and improved health care.

The Commission was told that mere token representation may increase consumer frustration. If participation is to be meaningful and helpful, it must be at a level where the consumer can really influence the policies and management of health-care organizations and institutions.

Effective consumer participation does not end all frictions between health-care providers and patients or solve all problems of health-care systems. It is merely one way of reducing these frictions and promoting greater understanding and satisfaction—creating a climate which, the Commission was told, has the potential for reducing the number of otherwise unwarranted malpractice claims. Consumer participation also can result in improved patient care.[8]

The Commission FINDS that where consumer participation has been successful, there has been a beneficial effect on the quality of health care and on increasing the satisfaction of the recipient community, which in turn has a beneficial effect on reducing the potential number of malpractice claims.

The Commission FINDS that the interests of health-care providers and the consumers are best served by effective consumer participation at the decision-making level.

The Federal Government has, under various OEO and HEW funded programs, encouraged or

[8] See Separate Statement by Ella Strother.

required consumer participation in neighborhood health centers, comprehensive health planning panels and hospital planning bodies. The success of consumer participation in these programs has varied considerably. However, the Commission recognizes the potential consumer participation has for improving the quality of care and the need for continued exploration in this area.

The Commission RECOMMENDS that the Secretary of Health, Education, and Welfare and the administrators of other Federally-supported health-care delivery and medical research and demonstration programs establish and continue consumer involvement activities at the planning, services, supervisory, management, and coordination levels by means of board membership, advocacy and advisory mechanisms.

The Commission RECOMMENDS that the same degree of consumer involvement be fostered by all appropriate non-Federal health-care delivery and research programs.[9]

[9] See Dissenting Statement by Monroe Trout.

Chapter 7

Prevention of Unnecessary Malpractice Claims

Many patients are moved to litigate because they are dissatisfied with the outcome of medical treatment and have been frustrated in their efforts to obtain either explanations, advice, or even a sympathetic ear, much less redress. It seems likely that many malpractice claims which involve minor injury could be prevented if patients only had some helpful person in a position of responsibility to talk to. A number of witnesses at our public hearings spoke of this need, and their testimony was convincing on this issue. This chapter deals with several ways we believe unnecessary malpractice claims can be prevented.

Patient Grievance Mechanisms

The Commission ordered a study of patient grievance mechanisms (PGMs) as they presently exist in hospitals, hoping to hear whether they have value in heading off malpractice claims.[1] The report showed that 27% of 1,040 institutions have some kind of formal PGM. In general, according to our study, these consist of a single person with a background in either nursing or administration. Most PGM's are designed to handle petty complaints over such matters as "red tape", billing or the quality of food. The person in charge of the PGM often does not have either the qualifications or the authority to deal with the medical aspects of patient care. It may well be that the settlement of a patient's small, non-medical grievances by a friendly and knowledgeable person could abate his feelings of alienation and frustration enough to head off a malpractice suit in some instances, but we have had no hard evidence to show whether this is so or not.

Two of the hospitals studied, however, had unique systems for dealing with potential patients' complaints or claims. While these systems cannot be characterized strictly as PGM's, since they are not oriented toward the routine handling of patient-care complaints, they have many of the features of other types of PGM's and could easily be converted into model PGM's for preventing many unnecessary malpractice claims.

In both cases they were headed by persons at the assistant or associate hospital administrator level with backgrounds in law or insurance. These

[1] *Patient Grievance Mechanisms*, Fry Consultants, Inc., APPENDIX.

individuals had authority to investigate all incident reports, and their judgements, supplemented by the medical information they were able to elicit from the hospital staff, were accepted by the hospital's director or its insurer as the basis for an offer of settlement of claims against the hospital. One of the two hospitals received a reduction in its malpractice insurance premiums that was attributed directly to this system.

The Commission believes that patient grievance mechanisms have considerable potential, presently largely unused, for (a) alleviating grievances that could lead to malpractice claims; (b) bringing about equitable settlements in the early stages of disputes; and (c) pinpointing within an institution procedures and situations that could lead to malpractice actions. While our study focused on hospitals, we are equally concerned that patients in nursing homes and other health care facilities have access to such mechanisms. We note that the Health Services and Mental Health Administration, Department of Health, Education, and Welfare, recently has funded five demonstration projects representing different types of investigative ombudsmen which hopefully will aid in improving the quality of nursing home care. One of these projects, sponsored by the National Council of Senior Citizens, is being tried out in the city of Detroit and in a rural area of Michigan. The other four are sponsored by the state governments of Idaho, Pennsylvania, South Carolina and Wisconsin. All of these projects are being evaluated to determine their effect on the quality of nursing home care.

The Commission RECOMMENDS that all health-care institutions establish a patient grievance mechanism capable of dealing with patient-care problems.

Voluntary Or Mandatory

We discussed at length the question of whether the above recommendation should be strengthened by requiring the establishment of such patient grievance mechanisms as a condition of receiving Medicare and Medicaid payments. It was recognized that if government were to make such a requirement, some institutions would simply set up patient grievance mechanisms on paper without really following through. Nevertheless, we felt on balance that a mere recommendation without enforcement would not adequately reflect the Commission's concern with this problem. Making it a mandatory requirement would insure that hospitals and other institutional providers would take a long, close look at the proposal and would make every effort to use it effectively, not only for the value it may have in heading off malpractice claims, but also as a useful tool to improve patient care, enhance patient satisfaction, and protect the dignity of the patient.

The Commission RECOMMENDS that the Secretary require, as a condition of receiving Medicaid and Medicare payments, that all health-care institutions establish a patient grievance mechanism capable of dealing with direct patient-care problems.

Non-Institutional Grievances

The Commission believes there should also be a mechanism to handle patient-care complaints that result from actions that take place outside an institution, notably in the doctor's office. In many parts of the country, patients can turn to local medical societies, many of which have established machinery for handling grievances. Often, however, patients do not know that such mechanisms exist. We were informed that the Alameda-Contra Costa Medical Association in California has placed advertisements in local newspapers suggesting that patients who have inquiries or complaints about their medical care get in touch with the association. In other places, unfortunately, medical society grievance committees either have limited areas of responsibility or are inactive or nonexistent. Thus, some patients who have complaints about care received in the doctor's office have no place to turn.

This is a complex problem, and we realize that it is impossible to suggest a single method that will work equally well in Pittsburgh, Pennsylvania and in Mason City, Iowa. But it is important that patients—wherever they live—have access to a mechanism by which someone can hear and act on all their medical-care complaints.

The Commission RECOMMENDS that, to the extent possible, patient grievance mechanisms be established to deal with patient-care problems in non-institutional settings.

Developing A Model

There is little information available on the best ways of staffing patient grievance mechanisms or of processing complaints. Our Commission study of PGMs has shown that there exists no quantitative data on the effectiveness of PGMs in improving quality of patient services, patient satisfaction, or reducing malpractice claims. Institutions have not developed criteria for evaluating PGMs based on clearly defined objectives. There was no way to determine which of the existing PGM staffing patterns was most effective because the institutions studied did not have measurable objectives and standards. Two of the hospital officials interviewed in our study claimed that their PGM was "worth its weight in gold." Such statements may be true, but it is doubtful if they are based on careful cost accounting or scientific evaluation of the plans in question.

The study ordered by the Commission included specific suggestions for patient grievance mechanism demonstration projects. More research is urgently needed both to support demonstrations with new types of mechanisms and to investigate existing ones. This research should determine the degree, if any, to which various approaches would work to reduce the incidence of patient dissatisfaction. Some pilot projects could be sponsored by Government, but the private sector also can do much by working on its own. The Commission encourages both approaches.

The Commission RECOMMENDS the initiation of research programs to determine the best way to utilize patient grievance mechanisms to deal with problems involving patient care, including all health care providers: hospitals, nursing homes, HMOs, clinics, and private practitioners, and also all levels of regulation—Federal, State, and professional.

State Offices of Consumer Health Affairs

During our hearings we heard again and again the complaint, "Nobody would listen to me. I had nowhere to go." Had the patient had someone to go to, someone who was informed, sympathetic and could explain things to him, it is possible that many cases could have been settled on an informal basis. If the patient has no one to go to except a lawyer, the problem will either develop into an adversary claim or result in another instance of rejection. It is still characteristic of medical care that the patient *trusts* the doctor probably to a greater degree than he trusts a member of any other profession or business. To bring suit requires him to make a complete turnaround, to switch from a position of trustful expectations and confidence to one of distrust and accusation. Most patients are apt to do that only with reluctance, yet no other avenue of redress may be open. Even this one may be closed if his claim is too small to be of interest to an attorney.

We have already recommended that all hospitals and other health-care institutions establish grievance mechanisms capable of handling patient-care complaints. These mechanisms should be capable of helping patients with all of their problems—whether they are caused by bad food, billing procedures, or health care. However, we believe that the patient should also have access to some form of external mechanism that could help resolve this problem, whether it results from care in or out of an institution.

There needs to be someone who can receive his complaint, conduct a preliminary inquiry into the facts, discourage complaints that lack merit, and make every effort to bring about an amicable, informal settlement of the meritorious complaint before it becomes a lawsuit. The Commission believes there should be special state offices to meet this need.

More and more, the states are creating mechanisms to handle the problems of consumers in general. Hence, this proposal is in accord with a popular trend. However, we perceive a major difference between existing offices of consumer affairs and the type of mechanism that is needed

here. Most state offices of consumer affairs are primarily concerned with the prevention or prosecution of fraud; they exercise primarily police functions. This is not what we have in mind in this area; policing functions should remain with licensing boards. What the Commission aims at here is analogous to an agency that mediates labor disputes. It is for this reason that the Commission believes that the office we recommend should not be a part of existing state consumer affairs agencies, but should have legal status as a separate agency. We also believe that its functions, which are discussed in detail below, should be differentiated from those of the state health departments.

An Office of Consumer Health Affairs, we are convinced, could help a great deal to head off medical malpractice actions by screening out unmeritorious complaints, and by bringing the parties together to make reasonable settlements. We have been told of cases in which the patient seemed more interested in punishing the doctor than in obtaining compensation. To the extent that an impartial and objective Commissioner can prevent this kind of action, he will be of great value to the health professions. To the extent that he can help the poor person or the one with a relatively small injury to obtain a reasonable settlement, he will be of great value to the patient.

The Commission also believes that the Federal Government should encourage the states to set up mechanisms of this kind, and we propose a positive incentive to stimulate their prompt development.

The Commission RECOMMENDS that there be established in each State an Office of Consumer Health Affairs. The Commission further recommends that Federal financial assistance be made available to the States to encourage the establishment of such offices at the earliest possible date.

It is the intent of the Commission that enabling legislation enacted by the Congress emphasize the positive inducement of Federal financial assistance, rather than any sanctions for non-compliance by the States within a reasonable time period. The Commission is particularly concerned that no sanctions be imposed upon the States for failing to establish such Offices of Consumer Health Affairs so that such sanctions will not work to the disadvantage of recipients of health care.

Duties of A Commissioner of Consumer Health Affairs

What powers should the State Commissioner of Consumer Health Affairs have? It is far from our intention to recommend that the states set up all-powerful officials who would have authority to regulate the medical profession or to interfere with the doctor-patient relationship. This point was emphasized and re-emphasized during our deliberations. But we do believe that this office must be a meaningful one.

We see the Commissioner primarily as a mediator and a friendly, sympathetic and understanding individual seeking to bring disputing parties together. We believe that such a person can do much to benefit both parties.

The Commissioner's work, however, would be of limited use unless the information that may be gained from his activities can be more widely applied. It is obvious that the privacy of the patient's personal medical records must be safeguarded, but the statistical information to be gained from the types of complaints registered must be utilized if improvement in patient care and the prevention of similar incidents is to be the net result.

The Commission RECOMMENDS that the duties of the State Commissioner consist of:

(1) Receiving and investigating complaints regarding the delivery of health care, with authority to take the necessary action to aid in resolving the alleged problems or complaints, including appropriate referral to other organizations within and without the State.

(2) Acting as an informal mediation and negotiation mechanism to aid in the resolution of complaints at the earliest possible date, before they mature into formal disputes.

(3) Establishing and maintaining records of health-care complaints, and related health-care causational factors and acting as a source for a central data bank,

(4) Periodically issuing public reports concerning information gathered by its officers for

the purpose of making recommendations for the improvement of the health-care system and improving the relationship between providers and users of health care, and

(5) Making the public aware of legal assistance mechanisms.

Efforts at negotiation through a mechanism such as we propose can be seriously hampered if either party fears that the give and take of negotiations will become a matter of official record that can be used against him in subsequent litigation. In other fields where this kind of procedure is used, statutes provide that nothing that is said or done during conferences or conciliation proceedings may be used later if the parties do not come to agreement and the matter proceeds to litigation. We believe that the same rule should hold in this case.

The Commission RECOMMENDS that no information, including documentation and results of investigation, obtained by the Commissioner in the course of carrying out his duties should be used as evidence in any subsequent adversary proceeding involving the same or similar issues. Moreover, nothing said or done during and as a part of such endeavors should be used as evidence in a subsequent proceeding.

All the recommendations in this chapter are related to the human dimension in patient care and are predicated upon the perceived need for enhancing the provider-patient relationship. In the final analysis it is the human interaction between all categories of health-care providers and patients that will determine the measure of success in the treatment process. We believe that increasing the degree of mutual understanding, courtesy, and respect between patients and health-care providers will greatly reduce the antagonisms, misunderstandings, and dissatisfactions which all too often prompt patients to turn to malpractice litigation.

Chapter 8

Resolving Medical Malpractice Disputes

Any formal system to resolve malpractice disputes shares the common goal of attempting to provide a just, speedy and inexpensive determination of the issues. A significant number of persons who are directly affected by the malpractice problem do not believe that the present system for resolving medical malpractice disputes meets these criteria. Justice is a relative concept which reflects the overall feeling of the community that the outcomes of the majority of disputes are fair. This feeling is an absolute requisite if any adjudicatory system is to survive.

The present system certainly is not speedy. Most malpractice claims take four or five years to resolve. The present system is also expensive. One need only look at the rising cost of malpractice insurance premiums to arrive at this conclusion.

We have already made some recommendations regarding improvements in the legal system in Chapter 4. In this chapter we will examine the system of handling and negotiating malpractice claims, and some of the alternatives to formal litigation which hold promise of ameliorating the present situation.

Claims Handling

In medical malpractice disputes direct monetary losses are usually incurred by insurance companies as indemnifiers of health-care providers. The insurance company is also required to conduct the defense of a medical malpractice claim or lawsuit on behalf of the health-care provider, regardless of the merits. Most malpractice insurance policies contain a provision requiring the insurer to obtain the health-care provider's permission to negotiate a settlement.

Insurers say that, in general, handling medical malpractice claims is more costly and more complicated than handling other types of liability claims. This is due to the distinctive nature of malpractice claims, and particularly the difficulty in determining whether or not such claims are in fact due to negligent conduct. The expertise necessary to make these determinations is expensive and the process is time-consuming.

Claims may be classified into three groups: (1) cases in which malpractice exists and efforts should be made to reach a fair settlement; (2) cases in which malpractice is questionable, but conditions point toward the desirability of working out a

compromise; or (3) cases in which malpractice does not exist, and the case should be staunchly defended.

However, not all insurance companies utilize this approach. Some carriers defend almost all cases, whether or not malpractice exists; while others are oriented more to the side of settlement or compromise. A few companies do not open a claim file until a lawsuit has been filed; others ask their policyholders to get in touch with their individual agents or brokers as soon as any untoward incident that might result in a claim occurs. Of the latter, some open claims files immediately; others file this information separately. To complicate matters further, practices within the same company often vary from region to region.

Because of widespread differences between companies in their claims handling, and data collection activities, it is extremely difficult to aggregate data for improved rate-making. The lack of industry-wide data also inhibits sophisticated loss-prevention efforts.

The Commission recognizes the importance of prompt and fair settlement of claims and FINDS that there are wide variations between companies in the way they handle claims. Some of these variations lead to inadequate data collection for rate-making purposes, inadequate information to support loss-prevention activities, and in some cases general cost-ineffectiveness.

Improved Claims Handling

Improved claims handling is clearly in order. The Commission believes that particular attention should be given to developing methods which will identify and resolve meritorious claims more rapidly.

Several major malpractice insurers presently are experimenting with advance medical payments to potential claimants. If a policyholder's patient is injured in the course of treatment, and the insurer has direct evidence that a claim with substantial merit might result, the insurer volunteers financial assistance to the injured patient and, in order to reduce the likelihood of a claim, will pay consequent medical expenses to try to rectify the situation. Of course, this is done with the policyholder's consent. It is also done with no admission of liability, and it does not eliminate the patient's right to file suit later on, if he so desires.

We believe there is merit in the concept of making advance medical payments and wish to encourage continued experimentation with this medical expense payment technique.

The Commission RECOMMENDS that medical malpractice carriers develop mechanisms for improved claims handling. In particular, we RECOMMEND attention be given to (a) the detection and analysis of incidents having a claims potential to allow early disposition of the case, and (b) further experimentation with advance medical payments.

Alternatives to Litigation

Litigation is a painful—even traumatic—personal experience for most people, whether they be plaintiffs or defendants. A formal trial is cumbersome, time-consuming and expensive. Its costliness often thwarts justice when a claim is so small that a contingent fee will not recompense a plaintiff's lawyer for the time and effort it would take to handle the case. The expense may also be unfair to a defendant if he has to spend substantial amounts of time and money fighting off an unwarranted claim.

The Commission, aware of the many defects of the present system for resolving malpractice disputes, and aware of some existing alternative methods of settlement, initiated a study and evaluation of those existing alternatives.[1] Our study revealed that, despite their number nationwide, these alternatives are not in widespread use. Only a small fraction of all malpractice claims are subjected to these alternative forums.

Thirty-eight existing plans were examined to determine their major procedural and substantive facets. The major focus of the study was to compare these alternative forums with each other and with the traditional legal mode of claims resolution and to assess their ability to provide a just, speedy and inexpensive determination of

[1] *Alternatives to Medical Malpractice Litigation*, Bird Engineering-Research Associates, Inc., APPENDIX.

controversies. The seven primary types of plans use one of two approaches to resolve malpractice disputes: screening panels or arbitration mechanisms.

Screening Panels

The screening panel is an administrative adjunct to the action at law, designed to permit early settlement of meritorious claims and discourage frivolous litigation. The main objective is to allow an allegation of malpractice based on substantial merit to be settled by the insurer without the necessity for the claimant to proceed to an action at law. Its procedure may be used before or after an action at law has been filed. In the vast majority of plans, the emphasis is directed toward using the screening panel before an action at law is filed.

Screening panels are customarily established by medical societies, either alone or in cooperation with bar associations. In six plans, the panels are composed solely of physicians; two other physician-only panels provide for advice from an outside party, such as a lawyer or clergyman. Panels composed of equal numbers of doctors and attorneys are used in 20 active plans.

The object in all cases is the same—to provide for a quick and inexpensive determination of whether or not a complaint has merit. The claimant may submit his case to the panel either before or after he has formally filed suit, though most plans encourage use of the panel before filing. There is usually a *quid pro quo*; if the panel finds that a claim has merit, it will provide the claimant with an expert witness; if it finds against him, he must agree to drop the claim. Panel proceedings must be useful to an attorney for either side in discovering at least the outlines of his opponent's case. Panels do not attempt to set money damages; after they have found a claim to be meritorious, the parties are expected to try to negotiate a settlement. Only if they cannot reach agreement does the case then proceed to trial.

However, many medical malpractice cases involve more than one defendant. The usefulness of screening panels in such cases is limited. A hospital, pharmaceutical company or manufacturer of medical devices which is named as a co-defendant may not be willing to submit itself to the judgment of a screening panel when it has not signed an agreement to do so. In fact, the study report to the Commission found that in comparable jurisdictions almost half of the cases that came to trial in court involved more than one defendant, but only 25% of the cases before screening panels did so. The jurisdiction of screening panels is also limited in another way. A medical society group is not likely to want to judge, let us say, an osteopathic physician or a dentist, nor would a member of those professions be likely to want them to judge him.

In those cases that screening panels do handle, how well do they succeed in their objectives? They do make the legal process less traumatic than court trial. They are relatively informal proceedings, held in private, without the usual newspaper headlines and the intimidating pomp of trial. Formal rules of evidence are not used and the hearings are short, usually lasting only a few hours or a day, and they are far less expensive than trials.

Whether the other hoped-for advantages are being realized, however, is less certain. Many of the screening panel plans are too new to have accumulated much meaningful data. The Commission debated the pros and cons of various forms of mediation mechanisms, including voluntary screening panels, and while we are not able to endorse all of such plans as truly workable or calculated to alleviate the tensions and problems that exist in this field, we do believe they merit continued experimentation. A significant aspect of our debate on this issue centered on the constituency of such panels, and we concluded that they should have lay representation.

The Commission recognizes the value of local efforts to mediate medical malpractice disputes; and therefore RECOMMENDS continuous experimentation with voluntary mediation devices. The Commission also RECOMMENDS that persons other than attorneys and members of the profession involved in the disputes be included as members of any mediation board or panel.

Arbitration

In the oral testimony at all of our public hearings, as well as in many of the prepared

statements presented to the Commission, there was constant reference to the utilization of arbitration as an alternative to the existing system of tort litigation. It became increasingly clear to the Commission that there was a paucity of basic knowledge, not only on the process of arbitration, but also on the results. It was obvious that many persons and organizations who had not analyzed the true characteristics of arbitration nevertheless believed that it was a method of dispute settlement that would make a major contribution to solving the malpractice crisis.

The Commission felt that it could make an important contribution not only by collecting and publishing information about arbitration not heretofore available, but also in making such an analysis. This we have sought to do.

Even among those widely knowledgeable in the field of litigation there is a lack of appreciation of the varieties of arbitration that are available or being utilized. This report cannot cover all variations, but it can delineate certain broad categories and indicate certain common characteristics, as well as major variables.

An oversimplified definition of arbitration is the process by which the parties to a dispute submit their differences to the judgment of an impartial party appointed by mutual consent or statutory provision. This, of course, is distinct from a resolution by a judge and jury in a formal court proceeding. The decision to arbitrate may be initiated by an agreement of the parties or it may be imposed upon them. Both approaches are now used for settlement of malpractice disputes.

Imposed Arbitration

Arbitration may be imposed by statute or by rule of court. Generally it is applied to disputes under a certain maximum amount and has been developed in certain jurisdictions to clear clogged court calendars and to expedite the administration of justice.

A limited statutory plan was recently enacted in New Hampshire for all professional liability claims (including those against lawyers, architects, engineers, etc.) without regard to the amount demanded. There all parties must arbitrate and the arbitrator decides upon liability and ascertains damages. His decision is not necessarily final; the parties may accept it or reject it; they may settle or sue. At a minimum, however, his decision gives them a solid basis for negotiation. The plan is so new that data is not yet available to show how well it is working.

In Philadelphia County and Allegheny County in Pennsylvania, the courts by rule have initiated a requirement for arbitration of all tort disputes involving less than $10,000. Upon completion of the arbitration, either party may demand a court trial, subject to certain economic penalties (e.g. taxation of court costs). Although information is inadequate for an evaluation of the results, this system of arbitration appealed to the Commission and it was suggested that it might well be tried on a broader basis and usefully compared with existing methods of claims resolution.

The question was raised whether or not, if an arbitration decision is appealed, the courtroom trial should be *de novo.*[2] The Commission concluded that no one should be denied a full-scale trial *de novo,* with all the evidence to be presented in open court, if the matter seems to him to be of sufficient gravity to justify that procedure. However, if he appeals and loses his case, the Commission believes he should bear some of the additional court costs.

In order to invoke the jurisdiction of the arbitration procedure, how does one determine whether a claim is worth say $10,000 or more or less? If the plaintiff's lawyer says it is worth less, there is no problem. If he claims it is more and the defendant's lawyer disagrees, a judge will make a pre-trial decision. The plaintiff is not thereby denied the opportunity to seek additional relief. He can go through the arbitration, appeal, and perhaps collect much more than $10,000 in the court proceeding. As a practical matter, however, the Commission was told, this is not a problem. Few cases are appealed when the upper limit is set at fairly small levels. We believe the decision as to what those levels should be should be left to the states.

Throughout the discussion of this topic there

[2] A trial *de novo* is conducted as though there had been no previous action. Thus, all factual and legal issues raised in the arbitration hearing may be raised again.

ran the thread of the question of who should do the arbitrating. There were frequent references to the question of consumer representation. No one opposed this in principle. Yet, few lay persons have the technical competence to judge the performance of a professional highly skilled in a particular discipline. At the same time, such decisions must not be left entirely to professionals if they are to be credible to patient-plaintiffs. Thus, we believe both groups must be represented.

What Should Be Done With the Information?

A question that aroused serious and lengthy debate among the Commission members was raised by the suggestion that information gained from malpractice arbitration actions be collated, studied and used to improve the quality of medical care through the continuing education of practitioners. Once again, there was no disagreement upon the end, but there was upon the means.

As one member of the Commission put it, "Unless you have a body of information built up as to what has been the result of a particular set of circumstances, you have to re-invent the wheel every time." Other members agreed, but said that they saw no purpose in identifying the parties, and, indeed, believed that there could be harm in so doing. Both a physician who has been wrongly accused and a patient who has had, for example, a mastectomy might not want the facts made public.

There was also the question of whether a report of an arbitration action should be sufficiently detailed to describe fully what happened so that everyone could benefit from the experience, or be so brief as to tell only what the decision was. If the sole object of arbitration is to save time and money, the latter is preferable. At the same time, if suit has been filed, or if arbitration is to be final, binding and enforceable by the courts, the result is generally made a matter of public record.

The Commission believes (1) it is desirable that the detailed results of all malpractice arbitration actions be available for study as groundwork for improving the quality of medical practice; (2) to the maximum extent possible the right to privacy of innocent individuals should be protected; and (3) the need for an inexpensive, fast means of settlement should be balanced against the need for feedback to improve the quality of medical care. In 40 states, an arbitration award must be filed with the courts and thus becomes a matter of public record, available to anyone who wants to see it. Weighing all factors, the Commission believes that the need to know is the most important factor.

We believe that the following recommendations, which establish the parameters for a statutorily-enacted alternative to malpractice litigation, should provide the necessary guidance to state legislatures that might choose to adopt an alternative to litigation in lesser malpractice disputes. We believe that such statutes would tend to relieve congestion in the courts, and provide faster, more equitable, and more agreeable resolution of medical malpractice disputes.

The Commission RECOMMENDS more widespread use of imposed arbitration as an alternative mode for resolving small medical malpractice disputes, providing the arbitration mechanisms have the following characteristics and do not preempt contractual arbitration agreements:

1. **Arbitration statutes enacted by the States should be designed to give jurisdiction over all parties, plaintiffs and defendants, involved in a specific medical malpractice case.**
2. **State arbitration laws should set a maximum monetary limit for invoking the jurisdiction of the arbitration board, with cases demanding higher amounts being handled through the present jury system.**
3. **Arbitration panels should include some persons who are neither attorneys nor persons involved in the delivery of health care services.**
4. **There should be the right of trial *de novo* subsequent to arbitration in the highest level jury court in the State.**
5. **The State arbitration statute should provide economic and legal sanctions, in order to discourage subsequent trials *de novo* of questionable merit, (e.g. via evidentiary rules, presumptions, taxation of court costs).**
6. **A fairly detailed synopsis of each arbitration decision should be made and published in order to establish precedents, provide information necessary to evaluate and improve the**

arbitration system, and provide adequate feedback information to the health care system.

7. **Although the Commission has recommended that the results of formal arbitration proceedings be published, publicity focused on the names of parties involved in disputes should be avoided or minimized.**

Arbitration By Agreement

Arbitration by agreement is not a new concept. It is commonly required in union contracts for the settlement of grievances, and many major industries handle disputes through the use of contract arbitration. Most construction and architectural agreements routinely include an arbitration clause.

Advantages commonly claimed for the use of arbitration include: (a) it permits speedier handling of claims; (b) it saves the time of the parties, the witnesses, and their legal counsel; (c) it permits the use of a sophisticated decision-maker or makers who may actually be an expert or experts in the field of controversy; (d) proceedings are informal and the technical rules of evidence may be relaxed; and (e) the decision is final, with a very limited potential of appeal. Finally, and perhaps most important in the field of professional liability, is the fact that the arbitration process is a fact-finding procedure conducted without the emotional overtones and adversary atmosphere of the courtroom.

On the other hand, critics of the arbitration process claim that (a) availability of arbitration may encourage small or nuisance claims; (b) being a more sophisticated tribunal, it may actually put greater values on loss of income as well as pain and suffering than a jury might; (c) the arbitration process may lead to more compromise judgments, rather than to clear definition of fault or no fault; (d) the non-public nature of the arbitration process not only makes it suspect, but protects those at fault and thus avoids the pressure of publicity as a device for coercing improvements in health-care practices. Many believe, moreover, that with all of its faults, there is no better method of resolving complicated disputes than the adversary proceedings in a courtroom.

Inherent in the debate is the basic question of public policy as to whether parties to an agreement should be permitted to avoid court litigation by use of a private tribunal. A minority of states do not recognize an arbitration award as enforceable, but most recognize the arbitration process and have established basic ground rules for its use. We believe all should do so.

The Commission RECOMMENDS that all states that have not adopted legislation to make possible binding arbitration awards, enact such legislation.

The use of contract arbitration in malpractice disputes is a far more complicated subject than is its application to disputes between contracting parties involved in normal business matters. In most malpractice cases there will be a multiplicity of defendants—doctors as well as institutions, and occasionally even a drug or medical equipment manufacturer. There is also the fundamental question of whether the arbitration agreement should be made as a basic part of the patient/physician/institution relationship *before* the event which gives rise to the dispute, or whether it should be made only *after* the event which gives rise to the dispute.

Legally, there appears to be no real difficulty with the parties settling their dispute through arbitration when the dispute is known and the parties then choose this alternative to tort litigation. There is little evidence of the use of arbitration in malpractice cases in these circumstances, although the American Arbitration Association has developed several limited pilot programs to test its effectiveness in this type of dispute.

Witnesses appearing before the Commission were primarily interested in developing a contractual requirement to arbitrate disputes based on events that happen after the contract is signed. However, they indicated little familiarity with the legal naunces basic to the creation of a binding agreement as a part of the physician/patient relationship.

The Commission heard testimony on three basic approaches to resolving the contract problem. The one with the longest history (more than forty years) was developed by the Ross-Loos Medical

Group in Los Angeles, California. The Ross-Loos Medical Group operates a closed panel medical plan available primarily to groups who purchase health insurance on a basis comparable to Kaiser-Permanente, but it is not hospital-based. In the insuring agreement, the following pertinent provision appears:

> "In the event of any controversy between a Member (whether a minor or an adult), or the heirs-at-law or personal representatives of a Member, as the case may be, and Ross-Loos (including its agents, employed physicians or employees), whether involving a claim in tort, contract, or otherside, the same shall be submitted to binding arbitration...."

The California Supreme Court held the above provision legally binding upon the minor child of a member who had received medical care under the terms of the above agreement. *Doyle* v. *Giuliucci*, 62 Cal. 2d 606, 401 p. 2d 1 (1965).

By validating the above arrangement, the court in effect held that the provision requiring arbitration was not invalidated by the doctrine of adhesion. Under the doctrine of adhesion a contract may be invalidated where one party, in an inferior bargaining position, is forced to sign a contract or forego an urgently needed service from one who is in a superior bargaining position. Since the provision was a part of the total health insurance package negotiated in advance, the problem of adhesion was obviated.

Since 1964, Ross-Loos has dealt with 35 claims alleging malpractice. Only three of these cases ever actually went to formal arbitration. In one case, the claimant won $70,000; the medical group won the other two and paid nothing. The claim that arbitration is speedy was not borne out by these cases: one took 42 months from the occurrence of the incident to final determination. Once the cases got to the arbitration panel, things moved fast enough; it was getting to that point that took so long.[3]

The remaining 32 cases were all settled in advance of arbitration. Only three involved substantial sums. Of 18 others settled since 1969, only one involved payment of more than $5,000, and the average payment was about $2,500. During 1971 and early 1972, 12 settlements for small sums were made to plaintiffs *without attorneys.*

Several questions are unanswered by the data: would the patients have won larger settlements if they had had lawyers, and, if so, would the difference have been great enough to have given them a net gain after paying legal fees? Were they paid "enough," whatever such a highly arguable amount might be? To what extent were the settlements kept down in size because Ross-Loos repaired injuries without charge, which, as a prepaid plan, it did. How much "free" medical service did it give, the costs of which, under other circumstances, would have been added to the patient's claim? Such questions indicate the obvious need for further study.

A ten-hospital experiment in Southern California takes a different approach. In this demonstration project, the arbitration agreement is included in the Conditions of Admission signed by the patient or the patient's representative at the time of admission to the hospital. In this situation the contractual relationship between the parties is initiated by the signing of the Conditions of Admission. Obviously, in many instances the patient was in immediate need for the hospital service. The pertinent arbitration language provides as follows:

> "Arbitration Option: Any legal claim or civil action in connection with this hospitalization, by or against the hospital or its employees or any doctor of medicine agreeing in writing to be bound by this provision, shall be settled by arbitration at the option of any party bound by this document. . . .unless the admitting physician has not agreed in writing to be bound by this provision, or unless patient or undersigned initials below or sends written notification to the contrary to the hospital within thirty (30) days of the date of patient discharge.
> "If patient, or undersigned, does not agree to the 'Arbitration Option,' then he will initial here._____"

Under no circumstances is the failure to agree to arbitration a basis for denial of admission to the

[3] *Binding Arbitration at the Ross-Loos Medical Group,* David S. Rubsamen, APPENDIX.

hospital. The patient is given the absolute right to refuse to arbitrate at the time of signing. Moreover, the patient is given an additional option to notify the hospital in writing within thirty days after discharge that he wishes to nullify the arbitration clause. The patient or his representative is given a copy of the signed Conditions of Admission and it is the opinion of counsel for the California Hospital Association that this procedure meets any possible challenge of adhesion. To date no legal challenge has been pressed to validate this opinion.

A third approach to creating an arbitration contract is employed by one malpractice insurance carrier (Casualty Indemnity Exchange) which requires, as a condition for granting a reduction in premium, that the physician policyholder obtain the advance written agreement of a minimum percentage of his patients to arbitration of any malpractice claim. This arrangement likewise has not been tested by court action as of this date.

The reports to the Commission indicated that neither the ten-hospital project nor the Casualty Indemnity Exchange program were meeting any substantial objection by patients to the arbitration clause. However, both programs are too new to have generated much useful information as to their effectiveness.

Contract arbitration may have certain other potential ramifications. Since it is based upon agreement, the parties can give broad discretion to the arbitrator or arbitrators as to the remedies granted to the patient. For example, the arbitrator could require the provision of continued medical care, or rehabilitation services, or an annuity award instead of a lump-sum payment.

The Commission is not prepared to select one method of arbitration over another; in view of the limited factual data presently available, it would be rash and imprudent to do so. The Commission believes, rather, in encouraging intense study and evaluation of those methods that are presently being used and of others that may be devised.

The Commission FINDS that the utilization of contractual arbitration as an innovative method of resolving malpractice disputes is an important development that justifies continued experimentation and study prior to universal adoption.

The Commission RECOMMENDS that no patient be required, as a condition for receiving service, to sign an agreement requiring him to agree to arbitrate any future dispute arising out of the service.

Note: This recommendation is not intended to apply to agreements for comprehensive health-care services in which the arbitration agreement may be a part of the overall contract for health-care services.

The Commission RECOMMENDS that the panel of arbitrators include representatives from the public other than members of the professions involved in the dispute.

Furthermore, the Commission RECOMMENDS that the results of contractual arbitration, including the award and the basis of the award, be made a matter of public record for the purposes of study and improvement of quality of care and the possible future avoidance of unnecessary injury to patients.

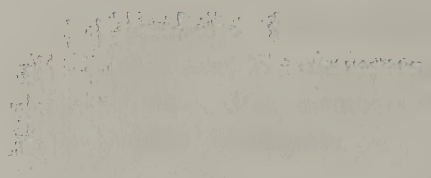
Coercion At the Federal Level

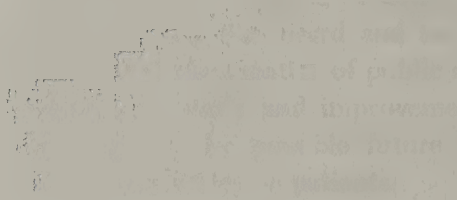
Several recent Federal legislative proposals have contained provisions which would require health-care providers, especially Health Maintenance Organizations (HMOs), to offer binding arbitration agreements to their patients covering all disputes which may arise out of treatment by the HMO. This would be a condition for receiving Federal financial assistance. The Commission believes that the same principle that invalidates arbitration agreements made under duress (the doctrine of adhesion) should also apply to the coercing of arbitration agreements by health-care providers as a condition for receiving Federal funds or obtaining other special benefits from the Federal Government.

The Commission is opposed in principle to any form of government activity which would

induce or compel a health-care provider or a patient to agree to arbitrate disputes prior to the event which gives rise to the dispute.

Some of the recommendations we have made in this chapter are quite extensive and they would, if acted upon, make major changes in our system of jurisprudence. The Commission wishes to caution any who might act upon these recommendations that it is not our intent to abridge anyone's constitutional rights to due process and equal protection of the law.





Chapter 9

Compensation for Medical Injuries[1]

What happens to the patient who suffers some adverse result of medical treatment, which may or may not be attributable to negligent conduct? How does he fare in his efforts to obtain restorative treatment, rehabilitation, or compensation for his losses under the present system? Although these are some of the questions the Commission considered of paramount importance, unfortunately, the Commission was not able, within its lifetime, to give the degree of attention to this subject that it clearly merits. Our major study dealing with this subject[2] was brought to our attention for discussion at our last meeting, and while it raised many of the important issues, it did not comprehensively explore all possible systems, nor did it suggest any definitive alternative for the Commission's consideration.

Perhaps some perspective can be gained regarding the magnitude and compexity of this issue when one considers the fact that it took the Royal Commission in New Zealand[3] two years to conclude its major inquiry regarding compensation for personal injury in that country. It took another two years of further study and debate before the New Zealand Parliament enacted legislation dealing with this subject. The problem is exceedingly complex and was recognized as such by the Commission.

Earlier in this report we dealt at length with ways to reduce the possibility of injuries in the course of hospital or medical treatment. We recognize, however, that even with the best injury prevention programs a certain number of patients will sustain complications or adverse results of varying degrees of severity and disability. At present, those patients have few options available to them. To the extent that their special economic needs are met through private health insurance or public health-care programs like Medicare and Medicaid, their incentive to bring lawsuits alleging negligence in treatment is proportionately reduced. But what about the severely injured patient who does not have private health insurance, Medicare, or any other economic cushion? He faces the

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[1] See Separate Statement by Richard M. Markus.

[2] *Non-Fault-Based Medical Injury Compensation Systems*, Calspan Corporation, APPENDIX.

[3] *Report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand* (Wellington: 1967), commonly referred to as the Woodhouse Report, after the Chairman of the Commission, Honourable Mr. Justice A. O. Woodhouse.

prospect of permanent disability or major loss of wage-earning capacity, and concurrently is faced with the problem of how to pay his enormous hospital and medical expenses. He may have no basis whatever for a malpractice suit, but given the above set of circumstances, his incentive to obtain financial relief through the mechanism of a malpractice suit may be overwhelming. What other alternatives does he have?

A great many witnesses at our public hearings urged our consideration of methods for compensating injured persons without regard to the issue of fault. The subject is one which is getting increasing attention in the press, largely due to the burgeoning interest in no-fault automobile insurance plans. In this context we felt is necessary to consider the possible virtues of alternative modes of compensating medically-injured persons, and one of our contract studies dealt exclusively with this subject.

The principle of compensating for injury without the necessity of proving fault is an old one and growing ever more popular. Workmen's compensation has been with us for many decades. Accident insurance, travel insurance, health insurance, automobile collision insurance, life insurance all compensate without regard to fault. In New York the physically-injured victims of criminal acts may be compensated from public funds and many other states are considering similar legislation. As noted, "no-fault" automobile plans are growing rapidly more popular.

While the present fault-oriented malpractice system has time-tested attributes which are beneficial, it also has many attributes that have led to dissatisfaction. For example:

(1) Payment of compensation to the medically injured person is, with few exceptions, delayed beyond the time when the patient needs it most: i.e., when he is making social and economic adjustment to his injuries.[4] This delay also creates major problems for health-care providers and insurers.

(2) Some injured persons who deserve compensation do not assert legitimate claims, because they find it distasteful to sue doctors. Others cannot obtain necessary legal assistance, either because they do not know how or because they cannot find a lawyer willing to handle the case on a contingent fee basis.

(3) The abrasive, caustic aspects of the tort liability system have caused widespread dissatisfaction. Health-care providers feel persecuted when they are sued. The personal stigma is great.

(4) The system is expensive to operate and very inefficient. It is estimated that a lower portion of the premium dollar is paid to medical malpractice claimants than to claimants under any other form of casualty insurance.

The Commission firmly believes that a working system for compensating losses due to medical injury should not be lightly discarded in favor of an untried substitute. We believe that improvements, supplements, and modifications to the present system should first be studied and only when proven workable should they be adopted.

A number of ideas and suggestions for compensation plans in which the necessity of proving fault might be eliminated were brought to the Commission's attention. A few examples:

(1) A system like that of workmen's compensation in which the medically-injured person is compensated automatically without regard to fault. It was proposed that in return for such compensation, medically-injured persons be denied the right to sue for negligence. (The Commission found the basic idea of such a compensation attractive but was not willing to recommend depriving the patient of his existing tort remedy.)

(2) The system recently enacted in New Zealand, which aims at the ideal that every accidentally injured worker, whether injured on the job, in an auto accident, in the course of medical treatment, or in other accidents, is entitled to full compensation, including economic reparation.[5] (The Commission believes that the differences between the two countries are too great for the proposed New Zealand system to be adopted here.)

[4] *Medical Injuries Described in Hospital Patient Records,* John S. Boyden, Jr., APPENDIX.

[5] *No-Fault Compensation for Personal Injury in New Zealand,* Arthur H. Bernstein, APPENDIX.

(3) The suggestion that hospital patients be given the option of purchasing insurance against medical injury in much the way that a person renting an automobile may voluntarily purchase collision insurance or a passenger on an airplane may purchase trip insurance.

(4) The suggestion that greater consideration be given to making advance medical expense payments to injured persons without regard to proving fault. Several major insurers are experimenting with this approach, as noted in Chapter 8.

In discussing any system of compensation without regard to fault, the Commission has had to face three realities. One is that any such system is bound to be more costly than the present one to the extent that it compensates injured persons whom the present system excludes either because their injuries were not due to negligence or because they are unable to prove negligence. The amount of additional cost cannot be measured, but it is certain to be considerable.

The second is that some form of national health insurance seem likely to be enacted in the not-distant future. The form that such an insurance program takes will undoubtedly alter significantly the impact that the malpractice problem has on all concerned. To the degree that it covers the cost of remedial medical and hospital care, such insurance should help alleviate the problem, but obviously the Commission cannot foresee the type of program that will be enacted or what its ultimate effect will be.

Third, and most important of all, is the extreme difficulty of defining the type of injury which would be compensable under such a new system. It must be remembered that the person who goes to a doctor or a hospital in the first place is already sick, or at least thinks he is. The nature of his ailment may be such that it would cure itself even without medical treatment, or it may be such that his condition will progressively deteriorate and he may die, regardless of all that medicine can do. It is the enormous difficulty of determining the threshold of compensability that all too often is overlooked, particularly by those who facilely suggest a no-fault compensation system for medically injured persons comparable to some of the automobile no-fault plans which have been proposed or adopted. There are radical differences between an automobile accident compensation system and a medical injury compensation system. We all have a reasonably clear understanding of the term "automobile accident." While there might be room for dispute in some instances, we can make generally acceptable definitions of "accidental injury" or "accidental death."

But what is a "medical accident?" A medical injury compensation system which is not fault-oriented presumably would authorize compensation for an injury which may be termed a "medical accident," an "untoward result," "a therapeutic misadventure" or some similar concept. All these phrases in substance describe an unanticipated event or result, and while they may be intelligible in the abstract, one is still faced in particular cases with the requirement to discover the causes of the compensable event.[6]

Most patients who die have been treated by hospital and medical personnel for the injuries or illnesses that led to their deaths. This being the case, should all such deaths be compensable incidents? While physicians can help to improve many conditions over a period of treatment, if the treatment takes longer than usual, or fails to improve the particular patient as much as expected, should these be considered compensable incidents? Should we compensate injuries which the patient knew might occur and, indeed, to which he gave his informed consent?

These are some of the difficult problems we face in seeking to develop any effective medical injury compensation system which is not fault-based. We are mindful of the strong urgings on the part of many health-care providers that some form of medical injury compensation system be developed *immediately* to alleviate the malpractice problem. The Commission, while aware of that concern, does not believe that we should leap headlong from a system that works (with however many faults) into an untested one that may cause even more severe problems. We cannot, within our allotted time and

[6]For a comprehensive analysis of the problems inherent in making such judgements, see Rubsamen, David S., "No-Fault Liability for Adverse Medical Results: Is It a Reasonable Alternative To the Present Tort System?" *California Medicine*, Vol. 117, page 78 (July, 1972).

resources, recommend the creating of entirely new compensation systems, but we can make recommendations regarding the need for investigating innovative approaches to such new systems.

The Commission FINDS that further study is warranted and essential for better definition of the event for which compensation for medical injury should be paid and for developing a method of financing whatever new system or systems are developed.

The Commission RECOMMENDS that the Federal Government fund one or more demonstration projects at the state or local level in order to test and evaluate the feasibility of possible alternative medical injury compensation systems.

The Commission RECOMMENDS that one or more State Governments study and investigate, by all appropriate means, including pilot programs, the feasibility of establishing a patient injury insurance program, similar to workmen's compensation insurance, to provide designated compensation benefits for injuries arising from health care, whether or not caused by medical malpractice.

In the Commission's discussions, dissatisfaction was expressed with several aspects of the current malpractice system, which might also be carried over into a new or modified system, unless great care is taken. For example, it was pointed out that the management of large sums of money is a skill that must be learned, and that to hand over such large sums to injured persons not trained in money management often works to their great disadvantage. We believe that serious consideration should be given to alternatives, such as awarding an annuity rather than a lump sum, or establishing a trust fund for the injured person's benefit in order to insure that the money remains available for the intended purposes.

Other areas which we believe warrant study and exploration include: speedy trials for medical malpractice cases; marshalling all sources of compensation, (for example, rehabilitation and disability compensation); advance medical payments funded by insurance or otherwise; compensation for the catastrophic medical accident not due to negligence; hospital accident insurance to be purchased by the patient; and the like.

The Commission RECOMMENDS that the various proposals suggested here be developed, tested and demonstrated through both public and private initiatives, especially those which, if possible, would promptly compensate medically injured patients without regard to a finding of fault.

Importance of Rehabilitation

The Commission believes that much greater emphasis should be placed upon physical and vocational rehabilitation than is now the case. We recognize that there is a severe shortage of both facilities and trained professionals in the field of rehabilitation and we hope that steps will be taken to remedy this situation. A substantial effort at rehabilitation, beginning immediately after the injury, may be costly at first, but if it restores the patient to a useful and productive life, both the individual and society will benefit in the long run.

Chapter 10

Implementation of Recommendations

In its short life span, the Commission barely reached the threshold of the serious problems that surround the malpractice phenomenon. We recognize the vital need to continue the work that we have begun, particularly in the area of research, but in other important areas as well.

Throughout this report we have made recommendations affecting many segments of society and many established institutions. In a few instances we have specified the most effective means for implementing those recommendations, generally by state legislative action. Many of our recommendations, however, call for joint efforts at the local level by a variety of concerned interests, and we did not specify any particular mode of implementation.

We are convinced that there must be a continuity of effort in this field, so that the momentum we have created for bringing about beneficial change will not be lost once this report is filed. The problems surrounding medical malpractice will continue unabated in the absence of definitive leadership by those who have the most at stake in the problem.

The Commission believes that this continuity can best be achieved by the establishment of a non-governmental, nonprofit organization which would become the focal point for dealing with malpractice problems now that our work is ended.[1] Such an organization should be broadly representative of all major interests—providers, the legal profession, the insurance industry, and the general public—and should undertake a variety of activities in the area of malpractice prevention, research, education and information. Without doubt, such an organization would need some form of Federal financial assistance in the nature of seed money to start the wheels turning. However, we do not see the need for significant direct Federal involvement beyond this initial stage except through the research grant mechanism, where Federal funds would be of great importance. By and large, we believe that operational costs of the proposed entity should be borne by health, legal and insurance organizations, and by philanthropic foundations.

The Commission RECOMMENDS the creation of a non-governmental, non-profit organi-

[1] See Dissenting Statement of Monroe Trout.

zation which would be the nationwide focal point for malpractice research, information, education, and prevention activities. The proposed organization should be broadly based and representative of the public at large, including health-care providers and third-party payors, both public and private, the legal profession, the insurance industry, and consumers.

Funding for this entity should come primarily from health, legal, and insurance organizations, as well as from philanthropic foundations and individuals. Federal assistance could come through the research grant mechanism and the sponsorship of conferences, particularly the initial conference and activities necessary to establish the organization.

The Task Ahead

This report could not and does not suggest final solutions to the many problems surrounding medical malpractice. It is merely a roadmap pointing the way to some possible solutions. One thing is clear: the problems we have dealt with have been given more careful scrutiny than ever before, and the chances for ameliorating these problems have been enormously enhanced.

We must remember that the problems of medical malpractice are dynamic social problems, shaped by influences which we do not always have the ability to control. We have recommended some new organizational modes for dealing with medical malpractice and we firmly hope they will materially assist in resolving some of the identified problems discussed in this Report. However, we point out that human hopes and aspirations ought never to be made dependent upon elaborate organizational mechanisms. In the final analysis it is the goodwill of individuals that will bring about the changes necessary to remedy the problems upon which we have focused. It is that spirit of goodwill, and the common need to work these problems out cooperatively, that will ultimately prove the worth of what we have begun.

Statement of George Northup, D.O.

This statement to the Commission is included here in its entirety at the request of the members of the Commission.

These comments may be a minority opinion but they are not a minority report. As the Commission's work draws to a close, I do not feel we physician members have conveyed adequately the reason why we react to the malpractice problem as we do. We have adequately demonstrated our reactions but not necessarily our reasoning. Because I believe it is necessary that all segments of the medical malpractice problem be better understood, I have allowed myself the luxury of reaction without due care to being unbiased or objective.

These comments are biased and they are subjective. This is essentially a gut reaction, the gut reaction of a single osteopathic physician. Perhaps it is pertinent to the purposes of this Commission to express this type of visceral reaction to some of the misunderstanding with which medicine and society must contend.

Medicine is a proud profession, on occasions perhaps too proud. It is true, and it has been repeated many times, that the quality of medical care in this country is the best in the nation's history. Despite defensive statements to the contrary, it is not always equally accessible to the consumer, regardless of socioeconomic status, race and color. Fortunately, this condition is changing, but not fast enough to meet the demands and needs of sizable segments of our population.

Perhaps we will never be satisfied, and this is good. But as a physician I live in an aura of fear—fear of suit. And fear contributes to hostility and rarely contributes to constructive action.

Medicine has some bad doctors and some bad health care institutions. We are not proud of them nor do we defend them. We are concerned with the correction and elimination of that element of the health-care community. Some do not believe we have this concern, but we do have it. It is my opinion that if these bad health-care providers were removed from the medical community overnight, the malpractice problem, or better stated the professional liability problem, would remain.

This Commission has heard a report which stated that, in a general examination of medical malpractice suits filed, approximately one-third were cases in which actual malpractice existed. Whether this figure is too high or too low, I cannot critically evaluate, but it must be admitted there is a sizable volume of cases not directly attributable to actual medical malpractice and I am not

convinced the remainder of the problem has been as thoroughly studied as it need be.

The professions of medicine continuously need to be improved. This will always be true. Medicine has done and is doing as good and as conscientious a job in this regard as any organized profession in existence, but there are gaps in this program of self-improvement, visible gaps that must be closed.

Recommendations have flowed from this Commission suggesting how medicine might improve itself, hopefully to ameliorate the professional liability problem. In general, the physician members have gone along with these suggestions which have been originated and supported by the consumer, the legal profession, the insurance industry, government, and medicine itself. As one member of the general medical profession, I feel many of these suggestions are excellent. Some are redundant because they are already being accomplished, and some are very difficult to implement, albeit desirable.

The house of medicine, however, feels belabored. Medical organizations are trying their best to overcome their deficiencies, but in my opinion medical malpractice litigation is not the best incentive to improvement. It places medicine in an adversary position from which hostilities too often result. This hostility has been demonstrated repeatedly during the hearings and meetings of this Commission.

As a physician, I seek no special immunity or support for our profession of medicine, but I do seek understanding--understanding of why we react as we do.

A medical degree does not confer an intelligent knowledge of government, law, insurance and consumer action. Medical-legal problems, complexities of the insurance industry, governmental function, and consumerism, are subjective areas of intellectual destitution for many physicians, and ignorance breeds fear.

It may be hard to believe, but we are a frightened profession. The doctor feels put upon. He feels nude on the corner of the Main Street of life. He often tries to cover himself with pride and even occasional arrogance, only to find himself being castrated. He really doesn't want to believe the hostility he feels, and often interprets it as being greater than it is.

Medicine, in my opinion, needs a greater inner humility. Its defensive pride is often translated into what appears to be arrogance and its fears into hostility, but having humility and being humbled by outside pressures are two different things.

Physicians must demonstrate to their patients even more rational confidence than they possess. The faith of the patient is important to the patient and his physician. Faith is a power and the physician continually feels it is being eroded by sometimes justified, but frequently unjustified, attacks.

Community reputation is a socioeconomic asset for a physician. The malpractice problem, he believes, tends to destroy this. His self-interest, if you want to call it that, and his reputation and credibility, is a far greater personal concern to the physician than the availability of professional liability insurance and its cost. The portrait of a doctor seemingly portrayed by some as an overpaid, callous, inhuman individual disturbs his ego.

I am told government officials, lawyers, and consumers have egos that get disturbed as well, and reactionary, ego-threatening situations do not always result in rational behavior. But our psychologists tell us that egos properly stimulated and developed are necessary for healthy psychological life.

Doctors are citizens, too, with rights and responsibilities. We are not, nor do we seek to be, a special class to be segregated into a socioeconomic ghetto for special privileges, special rewards, or special punishment. We, too, have civil rights.

Medical malpractice problems are socioeconomic in nature. An objective study of them resists any compartmentalizations into medical, legal, insurance, government, and consumer issues. This has been one of the problems of this Commission and has resulted in frequent wanderlusts into the never-never land of the Commission's main charge. Granted the Commission had to divide the issues to accomplish anything, but there comes a time when the parts must be fused into a unity, or the total problem becomes lost in specifics—the operation can be successful, but the patient might die.

Medicine is my sole area of alleged expertise. The recommendations directed toward the medical establishment by the Commission have been many. In most instances, these recommendations have

been supported by a majority of the physicians on this Commission. We have debated individual issues and voiced dissent, but it cannot be said that we ever voted as a bloc.

Medicine is not a union; its lobbying strength is frequently overestimated. I sincerely hope that medicine never becomes unionized, for medicine is essentially an art to which is brought every available and useful scientific fact. Medicine is not an exact science with exactly predicatable good or bad results.

Man, the object of medicine's concern, is a totally uncontrollable variable. Drugs can be standardized, but you can't standardize people. This simple statement implies some of the difficulties in rendering health care and the problem of avoiding distressing and sometimes complex diagnostic procedures.

Despite the fact that many physicians know little about law, insurance matters and consumer organizations, we do react to our many overlapping concerns. Sometimes our responses are necessarily more gentle and sometimes less so, but respond we do. Hopefully, some of the foregoing comments shed light on the reasons behind these responses.

As a physician, I hesitate to react to legal, insurance, governmental and consumer issues because I am sure there is much I don't know, much less understand, about the intricacies of these problems. For example, law and lawyers often leave me completely baffled. Few physicians are at ease in a courtroom. It is a foreign land and a foreign language. Perhaps because of this strangeness physicians respond to the law with undue fear. In fact, the role of the physician becomes that of the consumer, as far as law, insurance, government and consumerism itself are concerned.

Sometimes we physicians feel the need for an informed consent in these areas. We physicians, as consumers of the products of these groups, feel the need, oftentimes, of a statement of physician's rights. We, too, hear much of the responsibilities of physicians, but little of the right to pursue our profession in some freedom.

Physicians are urged to clean out the incompetent, the unskilled, and misfits in the house of medicine. We concur, but some of us feel the zeal being applied to ridding medicine of its misfits is less rigorously applied to the legal profession, insurance industry, and consumers. Bad doctors contribute to the medical malpractice problem, but don't bad lawyers, bad insurance companies, bad government and bad consumers contribute to the problem? Do the Commission recommendations adequately protect the physician against the evils as well?

We physicians don't often read the small print in our insurance coverage. We should. But when we read it, we frequently don't understand the words, much less the meaning. Are we not, then entitled to informed consent? Medicine is told to seek its own information concerning the risks of poor liability insurance. Isn't this as inappropriate as to tell the patient to seek his own information concerning the risks of medical procedures? Should not the American Insurance Association or some similar organization provide suitable guidelines to help in judging what is sound professional liability insurance and how to judge the fiscal responsibility of the insuranc company offering policies?

In my opinion, a major area of misunderstanding and lack of mutual trust is the area of the relationship between law and medicine. The misunderstanding between lawyers and doctors has surfaced several times in the course of this Commission's hearings. All of the bad relationships between the legal and medical profession do not exist solely at the malpractice level. The ethics and level of cooperation between medicine and law in several other areas is also troublesome.

There seems to me to be a growing need for lawyers and doctors to sit down and discuss their numerous contacts in other areas of involvement as well as in the malpractice area. It seems to me that bridges of trust and cooperation need to be built between these two great professions, not only in response to our own self-interests, but in response to the public interest, as well.

Consumerism is a magic word in contemporary society. No one knowingly wants to offend the consumer, but consumerism as a viable movement sometimes defies precise definition. Who does the consumer representative represent? All consumers? The poor or near-poor? Ethnic groups? And so the list can go.

Many of us believe in the principle of consumer representation, but who selects the consumer representation and from which groups? What does

one look for in a good consumer representative? What should our methodology of selection be? If there are bad doctors, bad lawyers, bad insurance companies, are there not bad consumers? Society should be protected against bad professionals, but should it not also be protected against bad consumers, as well?

Physicians often feel, whether rightly or wrongly, that consumers should have no special immunity against wrongdoing. Some of us are led to believe there are some purely litigious-minded consumers. Some of us feel that some consumers engage in a type of medical-legal lottery, and attempt to parlay an untoward medical event into a financial windfall. Medicine seeks no special protection of its own, but should there not be protective legislation against the person, whether he is a doctor, a lawyer, or a consumer, who abuses the courts of justice for purely financial gain?

The above reaction and questions are just some of the more visceral reactions physicians have in areas where they have too little, if any, expertise.

So what of this Commission and what of its report? This has been in my opinion, a good Commission. We quickly learned that despite our varied and considerable expertise, we were less than perfect. We have argued and voted against and with each other on many issues. Perhaps, most significantly, again, we have not had any group appear to have voted *en bloc*. We have voted as Commissioners with a common problem and a common commitment.

The report of this Commission, which was not available when I wrote these comments, will certainly not become a Magna Carta of malpractice, but I am sure all of us hope that it will be the beginning of a road towards alleviating the destructive tensions, the misunderstandings, and the rising costs of the malpractice problem in this nation.

Separate and Dissenting Statements

Separate Statement of Norma Almanza

Access to Medical Records

I dissent from the majority position on access to medical records through a legal representative because of my concern for the dangers and repercussions such a limitation could uncover.

It is my belief that a general consensus exists on the point that medical malpractice, at present, is viewed as a "crisis" only by the medical profession. This commission was charged with the responsibility of investigating and evaluating the malpractice problem from all points of view and with making recommendations for possible solutions to it. One of its first findings was that the breakdown of the doctor-patient relationship in recent years is a key factor in malpractice claims. Further investigation and testimony revealed rising dissatisfaction and frustration on the part of those seeking medical treatment, although it also indicated that the mass media have contributed greatly to the filing of many "nuisance" suits. Evaluating all these factors, it would seem that we, as a Commission, should explore new methods of dealing with consumer feelings of dissatisfaction and frustration. These methods could include education, changes in procedures, or even the institution of patient advocate mechanisms.

The Commission' recommendation, which condones denial of access to medical records to patients not represented by attorneys, will only further complicate and frustrate the individual patient who wishes to view his records himself, before he makes a decision to consult an attorney. This frustration will surely result in more suits being filed and more doctors being pulled away from their practices.

In addition, it is upsetting to me to see the medical profession's defensive reaction to free patient access to records. The growth of defensive medicine shows that doctors and others in the health-care community are reacting in fear to the threat of malpractice action. Such fear will only further confuse the public.

I am also concerned about the state of mind of a physician each time a lawyer comes to him for the record of a patient. If general anxiety about malpractice suits is already affecting his professional behavior, it seems likely that the increased

fear generated by a lawyer's entry into a patient's potential malpractice case will have an even more serious effect on the doctor's professional performance, both toward the patient involved in the claim and toward all his other patients. A physician's difficult tasks in diagnosing and treating illness requires the full use of all his mental faculties without the burden of emotional strain that fear of malpractice liability could produce.

The Commission believes that educating the consumer/patient to his rights and responsibilities is wise and helpful in keeping public expectations of the medical profession within the realm of reality. It must realize that newly-educated consumers are going to ask questions and want to see their medical records. Denial of patient access to records will only worsen the problem we seek to solve.

[The foregoing statement on access to medical records is concurred in by Richard M. Markus.]

Human Experimentation

The following dissent concerns the way the Commission handled the issue of human experimentation. It was the majority decision that although it was within our charge to encourage research under certain guidelines, to make sure that informed consent is available to research subjects, and even to express the feeling that children and the mentally ill should not be subjects of research, it was not deemed within our charge to make any mention of drug experimentation and its possible relationship to malpractice.

I strongly believe that although we did not go into any deep research on this subject, we can and should express concern about how experimentation with new drugs is presently controlled and who is controlling it. I, as a consumer and human being, am greatly disturbed by the point to which many of our doctors and citizens have arrived in viewing this subject. It is becoming the norm that nothing really shocks us anymore. Though it is said by all our great medical insitutitons that the quality of health care in the United States is the best in the world, we find ourselves in a health care crisis today. The crisis has reached such proportions that the consumer finally has come to realize that, unless he is directly involved in planning for a better health care system, he will be only the object of that system. I can no longer accept or believe that the medical community is effectively policing itself in regard to possible abuses in experimentation. There have been both government and private organizations assigned to control research, yet we hear of experiments that cost the lives of some of our citizens. These I can no longer accept as accidents. I consider them acts of medical malpractice.

Socio-Economic Distinctions

I dissent from the majority position on racial or class distinctions at both the teaching institution as well as private and public institutions, not because I do not agree that those distinctions should be abolished but because in the text of that recommendation we are only stating that we are in favor of what is already happening in many institutions. I am concerned when, though in theory we are seeking an end to a dual system of health care, we are really maintaining it by publishing a finding that states that teaching institutions explain to patients what will be expected of them. The Commission in one of its recommendations seeks to encourage the distribution of statements on patients' rights but I would be very interested in the "rights" of a patient in a teaching hospital.

Some of the Commission members made it quite clear that if a patient does not wish to be a teaching subject he should seek attention elsewhere. As a minority woman, and not so well off financially, I would like to educate those of the medical profession as to certain facts that are part of mine and any poor person's in the U.S.—everyday living facts. Though on paper many class distinctions are dying, we as a poor people can not chose any hospital or doctor we desire. Even the famous "green card" (welfare) does not act as an entry pass to the health-care system but rather as a branding symbol to further abuses and frustrations.

Though I have not been involved in health for the length of time of many of my fellow commissioners, I can say without the need of any intense research that due to this dual health-care system, those poor have become the patients of the teaching hospital. I look around Chicago with its' various medical schools and though to some

outsiders patient care at these teaching hospitals may seem a *nightmare*, to Chicago's poor it is a *reality*. And I know that there are many little "Cook Counties" throughout the nation. If the teaching hospital is to produce the doctors of tomorrow, how insensitive must it become to the sufferings of its patients, who suffer not only diseases of poverty that are very physical but also from a great social disease?

I do not wish to see the teaching hospital close its doors, but as a human being I would like to see it become a little more sensitive to its patients as human beings rather than objects of teaching. Maybe here I am naive, but I would like to recommend that teaching institutions offer patients the right to chose whether they would want to be seen by students or not. All of us as humans see the need for education, and I doubt that many will not consent to treatment, and though I am not a physician, as a human being I feel that acts of consideration given to a suffering person will place him closer on the road to recovery.

Separate Statement of Helen Creighton, R.N., M.S.M., J.D.[1]

It was a distinct pleasure to have participated in this distinguished commission on medical malpractice.

Although the commission worked hard and debated the issues, because this was the first effort to gather substantive data regarding the complex problem of medical malpractice, it was extremely difficult for the commission to fulfill its own expectations and the charge given it by Secretary Richardson.

I share the sense of urgency of the Secretary of HEW that the findings of this Medical Malpractice Commission be disseminated as expeditiously as possible. However, it is to be regretted that the Commission did not have an opportunity to meet and participate in developing the final report. Such a meeting would have minimized the need for separate and/or dissenting statements by commissioners.

I generally endorse those recommendations which focused on prevention of malpractice, improving the quality of health care and its delivery, the basic and continuing education of health professionals, and access of all who have suffered injury to a system of redress of their grievances. I also support the instituting of adequate grievance procedures for patients and a system of extensive public education regarding the nature of the problem.

Particularly noteworthy are the recommendations on human relations content in curricula to prepare health professionals, the improvement of the health care environment; and having insurance benefit structures that are easily understood by patients and providers. I am concerned about the placement and the working of the recommendations dealing with such subjects as mediation panels and arbitration lest they lead to the conclusion that the Commission wholly supported binding arbitration as the preferred method of settling malpractice claims. This was not a firm conclusion of the Commission although there was some support for experimentation with this and other means. I would not recommend that any method, including firmly-binding arbitration or no-fault insurance, be attempted which would lessen the degree of accountability of health professionals for the services they provide. The relative secrecy of such proceedings would tend to remove from public scrutiny the dimensions of the problem as well as mitigate against efforts directed toward injury prevention, education of the professionals and the public, as well as research.

I do support the search for innovative systems of compensation support; however, I would not include hospital accident insurance as an acceptable approach to providing financial protection to patients. In the public interest, not only should attention be directed to medical practice acts, but also to those of other licensed health professions such as dentists and nurses, so that examining boards may revoke or suspend licenses for professional incompetence. All such boards should be authorized to prescribe a range of intermediate disciplinary actions in addition to suspension or revocation of licenses.

[1] See also concurrence with entire statement of Howard Hassard.

Because of the inadequacy of some of the data presented, I support the recommendation urging the creation of a non-governmental, non-profit organization which would be the nationwide focal point for malpractice research, information, education and prevention activities.

Separate Statement of Howard Hassard, LL.B.

Preparation of Final Report

Today, January 17, 1973, I received the following telegram from the Honorable Elliot L. Richardson, Secretary of Health, Education, and Welfare:

"Thank you for your telegram of January 5 requesting an additional meeting of the Commission on Medical Malpractice to review further its draft report before submission to me on January 17. Your reasons for requesting more time are understandable and I can appreciate your concern. I am very much aware that the membership has worked extremely hard to resolve the problems surrounding the preparation of this complex report. However, in an effort to meet the Department's obligations, both of the President and the American public, it is my opinion that any further delay would not be justified in light of the importance of the Commission's findings and recommendations already developed. It is my judgment, and I hope you will agree, that the Commission's recommendations should be available for implementation at the soonest possible moment.

"I understand that the Commission members do have the opportunity to file separate views on any issue which came before the Commission as a whole. This procedure should provide an appropriate means for the Commission members to register their diverse opinions on a subject of great complexity and major importance.

"I would like to take this opportunity to express my deepest appreciation to you and the other members of the Commission for your thoughtful treatment of this difficult social problem."

I am at a loss to understand the Secretary's reluctance to permit the Commissioners an adequate opportunity to study, review and refine the Commission's final report and, perhaps more important, an opportunity to compare with each other individual comments, reviews and proposed improvements, in the light of the following facts:

1. Implementation of the extensive research, deemed necessary both by the Commission and its staff to fulfill effectively the original charge to the Commission by the Secretary, was substantially delayed due to factors beyond the control of the Commission, such as inactivity of the initial research staff and governmental procedural requirements. As a result, major research projects were not completed or available to the Commission until November and December, 1972, literally just before the stroke of midnight terminating the Commission's career.

2. Almost immediately after the Commission's creation, it was decided to conduct a series of public hearings in various areas of the United States, the purpose being to secure input from the public. No one has questioned the propriety of this decision and I cannot think of any counter-indication to the desirability of allowing the public to express itself. To do an adequate job, the Commission necessarily devoted the first half of its existence to public hearings. Bearing in mind that the Commissioners all have full time occupations and that essential research was hardly beginning, I submit that the time spent in public hearings was not unreasonable and did not impinge upon time available for deliberations.

3. The Commission met as frequently as material became available to it and completed the agendas prepared by staff at each meeting. Preliminary drafting of the Commission's report did not really get under way until the last two months of 1972, a fact attributable mostly to the late start on research programs and the late receipt of research results. The imposition of a December 31, 1972 termination on the Commission's life, coupled with the research delays, squeezed the Commission fore and aft, resulting in very little time to participate in report preparation.

The Commissioners received from staff the "Draft Final Report of the Secretary's Commission on Medical Malpractice" dated January 5, 1973,

between January 8 and 10, 1973. The Secretary's telegram points out that the report was required to be submitted to him on January 17, 1973. The Commissioners, all of whom have other obligations, were thus given less than a week to study and react to the entire report.

4. I am unaware of any deadline or of any factor that necessitates a report in January, 1973 as against Febraury or March of 1973. True, the medical profession and all others in the health field, as well as the general public, desire solutions to problems existing in the medical malpractice field, but I am certain that everyone concerned would prefer a thoroughly-studied document to one rushed through to meet an unexplainable hurried deadline.

In my opinion, the members of the Commission were given an inadequate period of time to review, study and propose improvements to the official report and were, unfortunately, denied an opportunity to meet together and, through comparison with each other's reactions, develop a true "Commission" report. There is no certainty, of course, that further time and an additional meeting would have improved the report, but those of us who served on the Commission will, I believe, continue to feel that we were given short shrift.

My statement is not intended to be critical of the hard working staff that spent many hours and many days drafting and redrafting our report. To the contrary, I compliment all concerned for a job well done under adverse conditions. I do feel it essential publicly to express my feeling as one Commissioner that the Commission itself was unnecessarily deprived of adequate opportunity to review its own handiwork.

[The foregoing statement is concurred in by Bernard Conway, Helen Creighton, Elizabeth Hidding, James E. Ludlam, George W. Northup, Carl E. Wasmuth, and Monroe Trout.]

Dissenting Statement of Charles A. Hoffman, M.D.[2]

Over a period of 16 months the members of the Commission have participated in numerous hearings, attended numerous meetings and vigorously participated with good will in the discussion of the issues presented for consideration. Although the votes on many issues were sharply divided, I am convinced that each member voted in accordance with his or her conviction of what is in the public interest.

The Commission considered and voted on approximately 100 separate issues which were presented to it in a rather random order. Although many findings and recommendations were adopted which I did not support, I have no criticism of my fellow Commission members in this regard.

As is indicated in the Report, the text which ties together and attempts to explain the Commission's finding and recommendations was written, not by the Commission or any member of the Commission, but by professional writers employed by the Commission. Drafts of this material were submitted to each Commission member for comments and suggestions. The decision on what changes would be made in these drafts were those not of the Commission, but of the Commission staff. Many members of the Commission requested an additional meeting at which the Commission could review and act upon the final draft of the Report, but there requests were denied.

Only after the final draft of the Report was assembled and distributed was it possible to accurately gauge the impact that the Report is likely to have upon the public and especially upon the health care providers. After studying this final draft of the Report, I am regretfully forced to the conclusion that the Commission has failed to accomplish the primary purpose for which it was established.

Such a charge cannot be made lightly and can only be substantiated by weighing the recommendations of the Commission against the specific purposes for which it was created. That is what I intend to do.

That primary purpose is set forth in Statement of Formal Determination, issued by the Secretary of the Department of Health, Education and Welfare as follows: "The Commission will advise the Secretary with respect to the entire range of problems associated with professional liability (malpractice) claims against all categories of health care providers and institutions in both the Federal

[2] See also concurrence with statement of Monroe Trout on legal doctrines.

and private sectors, and will make recommendations as to legislative, administrative and programmatic actions calculated to ameliorate the problems so identified." Despite the expenditure of approximately $2 million, the performance of many research and statistical studies and the devotion of countless hours of time and effort by the Commissioners, the Report of the Commission does not appear to be calculated to ameliorate to any significant degree any of the problems of malpractice claims against health care providers and institutions. Indeed, some of the recommendations, if implemented, seem likely to stimulate an increased frequency of claims which would produce an inevitable increase in the cost of health care to the public.

The circumstances which gave rise to the appointment of the Commission were the extended period of increasing claims against health-care providers and institutions. These were reflected in skyrocketing liability insurance rates, which in some instances rose ten-fold in ten years. More important, critical local problems of providers had unavoidable adverse effects upon the public—the patients whom the health care providers serve.

Fear and anxiety over liability risks and loss of insurance protection among providers had an unavoidable adverse effect upon patient care. If every patient must be considered a potential legal antagonist, from the necessity of self-preservation, the provider-patient rapport must suffer. Regardless of the "miracles" of modern science, harmonious interpersonal relationships and trust are essential for the most effective and successful health care. This harmony and trust was and still is being destroyed by malpractice litigation.

For these reasons, the public, in its concern for the best possible medical care, and the health care providers, in their desire to provide that care free from the fears and anxieties of these unprecedented legal risks, welcomed the establishment of the Commission. The public and the providers both have looked forward in hopeful anticipation to results of the Commission's activities which would provide some practical, helpful and effective solutions to these problems. These expectations may have been unrealistic, but it appears likely that the Report of the Commission will leave both the public and the providers bitterly disappointed.

The Report fails entirely to identify the medical malpractice claims problems for what they really are. These problems are an integral part of the much greater problems of general liability claims and litigation. These problems include automobile liability, product liability, airline and rail liability, homeowners liability and all others, including malpractice liability. The malpractice claims problems are only the most visible part of the general problems and the part where the results are most disastrous because they adversely affect the nation's health care.

The United States has always been very litigation prone. Its people have always been quick to file a lawsuit seeking damages for virtually any injury, real or imagined. In recent years, the habit of litigation has been increasing to virtually orgy proportions. In the personal injury field, of which malpractice is a part, litigation is encouraged by the contingent legal fee system which permits a claimant to file a lawsuit with little, if any, financial risk. This system is widely used only in the United States and not at all in most other countries.

As a result the United States has, in relation to its population, more litigation, more courts, more judges, more lawyers and higher costs of litigation and liability insurance rates than any other country in the world. This general litigation and the costs and problems which it generates are continually increasing every year.

General litigation is further stimulated by the clearly apparent trend in the courts and the legal system toward imposing greater risks of liability in virtually every aspect of human activity. The courts are continually establishing new rules of liability, new rules of evidence, and new rules of procedure to make it easier for any injured person to recover substantial damages from someone for virtually any injury he suffers. If this trend continues to its logical conclusion, anyone who engages in any activity will have to pay full damages to any other person who is injured in any way even remotely associated with that activity, regardless of what caused the injury.

This trend is also clearly apparent in the field of malpractice litigation. Let me make it clear that I, like other physicians, affirm that any patient who is injured in the course of his health care as a direct

result of misconduct or negligence on the part of any health care provider or institution is entitled to just and reasonable compensation for his injury. A burden of compensation for injuries should not be imposed on providers or institutions, however, merely because an injury has occurred, in the absence of any misconduct or negligence. To do so increases the cost of health care without any justification.

In line with the general trend toward increasing liability outlined above, the courts have, in the field of medical malpractice, imposed this unwarranted burden upon providers and institutions by adopting new rules of liability, evidence and procedure which make it easier for claimants to recover damages against such providers and institutions with little, if any, proof of misconduct. With only insignificant exceptions these new rules apply only in lawsuits against health care providers and institutions. They include: (a) the "discovery" rule under the statute of limitation, (b) application of the doctrine of res ipsa loquitur to injuries arising out of the performance of professional services, (c) the doctrine of "informed consent," and (d) a rule allowing liability based on an alleged oral guarantee of good results. Application of these and similar new legal doctrines have inevitably increased the cost of health care. The Commission should have made a clear and strong recommendation for appropriate and equitable remedial legislation to correct these discriminatory legal doctrines. Instead of facing this need squarely, the Report recommends referral of the legal doctrines to some vaguely defined and presently nonexistent group which is supposed to develop recommendations for uniform rules of law "in the nature of a Restatement of the Law of Medical-Legal Principles."

Uniformity of law is desirable only if it is uniformity of good law. Uniformity of discriminatory law would only compound the evil. No unofficial group, such as that proposed, can change any of the discriminatory legal doctrines which have been established by the courts. As a practical matter, these rules can be changed only by appropriate remedial legislation. Some remedial legislation has already been adopted in some states. If the Commission had strongly urged such remedial legislation, it would have been more helpful in achieving amelioration of the problems.

My views on these legal doctrines and the appropriate remedies are set forth in more detail in one of the seven separate statements which were submitted by me and which are published with the Report. These statements were submitted by me to the Commission, together with appropriate accompanying recommendations, for consideration and action by the Commission. When it appeared that the Commission was unwilling or unable to consider and act upon these proposals, I submitted them for publication with the Report as my separate statements.

I believe that these separate statements cover those areas of the problems of medical malpractice claims which are of the greatest importance and contain recommendations which, if implemented, would be most conducive to ameliorating those problems. I believe that many members of the Commission would have agreed with these statements and recommendations if they had been given an opportunity to consider and vote on them.

Regrettably, the Report offers little that is likely to ameliorate the problems associated with malpractice claims. Indeed, some of the recommendations, if implemented, would be likely to increase the cost of health care or impair availability of health care manpower without any significant benefit with regard to the problems of medical malpractice claims.

Without any statistical or evidentiary proof, the Report tends to give the false impression that the rapid increase in recent years of the frequency and cost of malpractice claims has arisen from a deterioration in the general quality of health care. The reality is that the general quality of health care has been dramatically improving during the same period of time when the frequency and cost of claims have been increasing. It is this paradox which is most frightening to health care providers. It seems to them that the more the general quality of care is improved the more malpractice claims arise.

I am sure that the Commission did not intend to take action which would increase the frequency of claims, but it seems clear that the implementation of some part of the Report would inevitably have that result. For example, the provision of public legal assistance for those unwilling to represent them will undoubtedly stimulate more claims. With

the taxpayer paying the legal expense, there would be no deterrent to claims or lawsuits regardless of whether the claims had merit. Although no one should be denied justice solely because no lawyer is willing to represent him, there must be some way of handling this problem without an open invitation to additional claims, such as a compensation system discussed later in this report.

The Report recommends establishment of compulsory patient grievance mechanisms. This is a desirable method for handling patient discontent that unavoidably arises in the cause of health care. Extending the procedure beyond that scope to include damage claims, as the Report suggests, is likely to both defeat that purpose and to stimulate unwarranted claims. Others more appropriate methods for handling claims, such as screening panels, arbitration and mediation are covered elsewhere in the Report.

The Office of the Consumer Health Affairs which the Report recommends for every state, would be empowered to receive and investigate complaints, to seek to settle complaints, and to refer complainants to legal assistance programs. The nature and functions of this office would, of necessity, stimulate additional claims. Consumer protection is generally desirable but it would seem that it should be possible to achieve that objective without stimulating more malpractice claims.

The major concern of every health-care provider is the welfare of his patients, who are the health-care consumers. The rights of patients must be protected. This is an objective pursued as vigorously by the health-care providers as it is by any consumer organization. There is need for improvement in this, as in any other aspect of human affairs and there is understandable disagreement as to the best methods to accomplish the goal. Stimulation of more claims, with their attendent antagonism, does not seem to be the best way to assure patient welfare.

The Report stresses the obvious fact that, if there were no injuries in the course of health care, there would be no malpractice claims. Granted this truism, it must also be recognized that, where the health care of a patient demands intervention by surgery or potent drugs, the risk of injury is unavoidable. Although no accurate figures are available, it should not surprise anyone that the number of health care injuries per year is high. All available evidence, however, indicates that only a very small percentage of such injuries are caused by the misconduct or negligency of anyone.

One of the few constructive recommendations included in the Report is that calling for development of injury prevention programs for every health care institution. A similar proposal is included in one of my seven separate statements.

There is reason to believe that any substantial reduction in the frequence of such injuries, however caused, would eventually have some beneficial effect upon the frequency of malpractice claims. Injury prevention, even at optimum performance, would not eliminate all claims and any reduction is likely to be slow in making itself manifest.

Even with the best efforts to reduce the frequency of injuries, some will always continue to occur. Many are the unavoidable consequences of necessary health care procedures. Some are the results of human error, which cannot be totally eliminated, since neither patients nor providers are infallible machines.

When a patient does suffer a substantial injury, he does need economic assistance for himself and his family. That need is just as great whether the injury was caused by someone else's fault or not. If no other source of assistance is available, he will be under great pressure to make a malpractice claim to meet those needs.

Although the Report does not specifically recommend the adoption of a compensation system which would not require proof of fault on the part of a health care provider or institution before the economic needs of an injured patient could be met, it did recommend experimentation with such systems, which is also a constructive proposal. The easiest way to achieve this result would be to extend existing workmens' compensation laws to cover medical injuries on substantially the same terms that industrial injuries are now covered. Such compensation not based on liability would undoubtedly be more costly than the present liability system. It would, however, provide more benefits to more injured patients. If a system of this kind is adopted, however, it should be done in a way that would not add to the cost of health care.

Other constructive proposals are those related to data collection, at least in part. Accurate and

reliable data about medical malpractice problems have previously not been available. Some of the data is urgently needed to help to ameliorate the problems of medical malpractice claims. In one of my seven separate statements, I have indicated the appropriate scope of data collection.

The Report, however, goes beyond practical limits on data collection. It calls for collection of data on many different subjects from many different sources, without any determination of what kind of data is really worth collecting. Data collection and processing is too expensive to plunge into wholesale without careful cost justification.

One of the reasons why the Commission did not present more constructive proposals appears to be the unfortunate circumstances that it spent too much of its time debating issues which had little, if any, relationship to the frequency or cost of malpractice claims. While these issues may have been important ones in relation to health care generally and may have some possible association with malpractice claims, the result was many recommendations that are likely to have little, if any, beneficial results toward amelioration of the problems of medical malpractice claims.

Everyone agrees that more and better education on the undergraduate, graduate and continuing education levels is highly desirable for all professionals, including health care providers. No evidence has been found, however, statistical or otherwise that deficiencies in health care education at any level have been a significant causative factor for the increasing frequency and cost of malpractice claims. Accordingly, improving education is not likely to have any significant effect in reducing the frequency of claims.

Everyone also agrees that licensure and disciplinary proceedings by the state licensing boards should exclude from patient care all providers who are professionally incompetent and a hazard to patients who come under their care. Again, however no evidence statistical or otherwise established that laxity in licensure or discipline had any significant causal effect upon the frequency or cost of claims. Better licensure regulation may be desirable, but it is not likely to significantly ameliorate the problems of medical malpractice claims.

Everyone further agrees that health care providers, whether on the level of general practice or specialty practice, should maintain their professional competence on a continuing basis. Here also, no evidence either statistical or otherwise was presented that failure to maintain professional competence was a significant causative factor upon the frequency or cost of malpractice claims. Maintenance of professional competence should be encouraged, but it seems unlikely to have any significant effect on malpractice claims.

Everyone again agrees that hospital staff privileges should be regulated so that health care providers will limit their activities to the scope of their established competence. Again, however, there was no evidence statistical or otherwise that failure to properly restrict staff privileges was a significant causative factor for the frequency or cost of malpractice claims. Hopefully regulation of staff privileges will continue to improve, but it seems unlikely that such improvement will have any significant effect in ameliorating the problems of malpractice claims.

Everyone agrees that medical research should be governed by ethical principles which carefully protect the rights of patients or subjects who participate in such research. Here, also, no evidence statistical or otherwise was found that unethical research practices were a significant causative factor for the frequency or cost of malpractice claims. Ethical principles in medical research must be rigorously enforced, but there is no reason to believe that such enforcement will significantly ameliorate malpractice claim problems.

The Report contains many varied recommendations in addition to those mentioned here. These recommendations involve activity by health care providers and institutions, by the legal profession, by the insurance industry, by consumers and by federal and state governments. All of these recommendations, if implemented, would involve some costs, and in many instances substantial costs. It is not possible to make any realistic estimate at this time as to what the total costs would be. I believe, however, that it is safe to say that the total cost would be staggering, if all of the recommendations were implemented. If these costs were added to the cost of health care, the results would be tragic for the public.

[The foregoing statement is concurred in by Audra Marie Pambrun.

"I heartily concur in the dissenting report of Dr. Carl A. Hoffman except where it may differ in emphasis from the dissenting statements which I have submitted on particular issues."—Monroe Trout.]

Medical Malpractice Problems

Medical malpractice is a failure on the part of a provider of health care to conform to accepted standards of skill and care or other misconduct which causes injury to a patient. The essential element of the problems of medical malpractice is the need for assistance which arises when a patient is injured by medical malpractice in the course of his or her health care. An injured patient needs prompt and effective remedial care. He or she needs replacement of lost income for his or her support and that of his or her family. He or she may need rehabilitation. These needs are just as great regardless of whether his or her injury was a totally unavoidable consequence of the health care or whether it was caused by the substandard skill or care of providers of health care.

This needed assistance necessarily involves cost. The problems which have confronted the Commission are fundamentally related to the amount of money needed to satisfy these needs, its sources, adequacy, availabiltiy and methods of allocation.

It is obvious that the need for financial help does not arise unless a patient is injured in the course of his or her health care. Since any health care procedure inherently presents some risk of injury, it is not surprising that there are many patients who are injured in the course of their health care. Fortunately, most of the injuries are not permanent or of great severity.

Of the many injuries to patients which occur every year only a small percentage are caused by substandard performance or misconduct of providers of health care. Only this small proportion of the injuries are legally compensable. Nevertheless, where an injury is permanent and severe, a claim for legal compensation is likely to arise regardless of how the injury was caused, if the patient has no other source of financial assistance available. Whether these claims are successful or not they add to the cost of providing compensation for legally compensable injuries.

If every patient whose injury was caused by medical malpractice was fully compensated for his or her injury, there would still be a greater number of injured patients whose need for financial assistance would remain unsatisfied. Many of these patients would inevitably make claims for compensation which would add to the cost of compensation without helping to meet that need.

Recommendation 1

Some way should be found to meet critical financial needs of patients arising from injuries in the course of their health care which were not caused by the fault of anyone and which are not otherwise compensable, provided that the financial assistance should come from private or governmental sources which will not add to the cost of health care directly or indirectly.

Statistical Data

At the outset of its deliberations, the Commission was confronted by the fact that there is very little accurate, current, reliable and complete statistical data on any of the various aspects of the medical malpractice problems. Accurate information about the problems would have been helpful in determining their nature, seriousness, causes and possible remedies. The only clearly established data initially available to the Commission was that showing the rapid increase in cost of medical malpractice liability insurance in recent years.

At the present time very little additional accurate and reliable statistical data is available. Although the Department of Health, Education and Welfare has contracted for a number of studies and surveys on behalf of the Commission, the final results of none of these studies were available to Commission members at the time when the Commission started making decisions on findings, conclusions and recommendations for inclusion in its report.

Precise and reliable numerical data is still not available concerning most aspects of most of the problems considered by the Commission. Enough is known, however, in broad general terms to warrant the findings, conclusions and recommendations contained in this report. Nevertheless some current, reliable and specific statistical data would

certainly be advantageous in the continuing efforts that should be undertaken in the public interest to minimize the problems of medical malpractice.

If an attempt were made to gather and analyze all possible data on all elements of the problems of medical malpractice, the undertaking would be vast, cumbersome and grossly expensive. Moreover, much of such data would probably be of little or no benefit to the public.

The expense of data collection and analysis is such that it can be justified only if there is an expectation of useful results. Since the most important objective in minimizing the problems of medical malpractice is to minimize the frequency of injuries to patients in the course of their health care, data collection should probably be limited to that which offers a strong probability of aiding that objective. To minimize the frequency of injuries, it is essential to know the nature, frequency, severity, circumstances and causation of the injuries. Substantially all of that information is presently recorded in some form in the closed-claim files of insurance carriers and in hospital records.

Total collection and analysis of even this limited data will be a formidable and expensive task. Study may show that a statistically selected sample of the total data will achieve virtually equal results at much less expense.

Collection of other kinds of data is not of such obvious benefit. It should not be undertaken unless it can be domonstrated that it is likely to achieve results which will be beneficial to public welfare. In all cases, pilot programs to test the merits of any specific data collection proposal should be established to test its usefulness before a commitment is made for the necessary expenditures for a full scale program.

Recommendation 14

A system should be established for the collection and analysis of statistical data on problems of medical malpractice only to the extent that such activities are found to afford a reasonable expectation of beneficial results toward minimizing these problems, as established by appropriate pilot programs. Primary emphasis of the data system should be directed toward minimizing the frequency and severity of injuries suffered by patients in the course of their health care, based on data from closed claim files of insurance companies and from hospital records. The data system should be operated on the most economical basis consistent with achievement of the desired goals.

Legal Profession

The legal profession, including the courts, is very directly involved in the problems of medical malpractice. Lawyers are not in any way responsible for injuries which occur to patients in the course of their health care, although lawyers, in the performance of their professional services, do sometimes cause injuries or losses to their clients and are recently being subjected to an increasing number of liability claims.

Once a patient injury has occurred, however, the legal profession has a very direct impact upon the consequences. Whether the injured patient consults a lawyer or not may be determinative of whether or not a claim for compensation is made. Once a claim for compensation is made, it is almost inevitable that its outcome will be affected by lawyers, both a lawyer for the patient and a lawyer for the provider and his insurer. Lawyers and the courts will essentially determine whether compensation is paid and how much.

A patient-claimant is almost invariably represented by a lawyer on a contingent fee basis, under which the lawyer will receive a percentage (usually one-third to one-half) of any compensation recovered by the patient, plus reimbursement of expenses of litigation which have been advanced by the lawyer, but will receive no compensation for his legal services if the claim is unsuccessful. This arrangement appears to be highly satisfactory to both the claimants and the lawyers who represent them.

Under the legal contingent fee system it appears to be true that the lawyer serves a function of screening claims prior to the formal initiation of a claim against the provider. Although there is no accurate data, it appears that lawyers consulted by an injured patient quite frequently decline to represent the patient as a claimant. Usually the reason for doing so is that the injury suffered is not sufficiently severe to warrant any substantial amount of compensation, although sometimes the reason may also be that the injury is clearly not

legally compensable. This is understandable because the attorney who is to be compensated solely on the basis of a percentage of the recovery cannot afford to invest his time and professional skills if the anticipated payment for his services is small or non-existent.

On the other hand, where an injury is permanent and of a serious nature, it is likely that the amount of compensation would be very substantial if liability can be established. In these circumstances the lawyer is more likely to agree to representation, even though the issue of liability may be very doubtful. With the anticipation of a large percentage legal fee, the lawyer is more likely to take a chance that he will be able to find some basis for liability or will be able to persuade a court to establish a new basis.

If a patient is permanently and severely injured as a result of substandard care by a provider of health care, he needs and is entitled to a very high dollar amount of compensation. Where justifiable compensation reaches the level of $100,000 or more, it may be questionable whether the present contingent fee arrangement is truly beneficial for the injured patient.

If the patient actually needs $100,000 because of his injury, but actually receives less than $66,666 after his lawyer's contingent fee and expenses of litigation are deducted, the patient is seriously undercompensated. At these higher levels of compensation there is a likelihood that the patient's lawyer receives compensation for professional services which is excessive in comparison with the compensation for professional services paid the provider's lawyer on an hourly basis. This is especially true where there is a large settlement without litigation which necessitates only a relatively small expenditure of time by the patient's lawyer.

Whether the contingent legal fee is desirable or not from a public welfare viewpoint, there seems to be little likelihood that it can be eliminated. The most that is likely to be accomplished in the foreseeable future would be some regulation of the percentage fee. Some regulation of this nature already exists, but does not appear to be sufficient to really protect the interests of the patient-claimant. It appears that a strong public interest argument could be made for at least a percentage fee scale that would decline in steps as the amount of compensation recovered increases to the higher levels.

Regardless of fee arrangements with attorneys, claims for compensation for injuries suffered in the course of health care are subject to the general procedures of tort litigation. This means that they are subject to jury trial. Although the results of a particular jury trial may vary greatly on either side of a theoretical norm of "justice," it is generally agreed that on an average the results of the adversary proceedings of jury trials approximate "justice" more closely than any other procedure which has yet been devised. This procedure, however, is expensive, slow and inefficient. It also often produces individual results which are a far departure from ideal "justice."

The unsatisfactory elements of jury trial adversary procedures have led to a number of alternative remedies. Most notable of these is the workmen's compensation system which permits recovery of limited compensation for injuries suffered in employment without the necessity for proof that the injury was caused by negligence, which provides for administrative proceedings rather than court litigation, and which bars suits for liability compensation under general legal rules. Another alternative remedy which has become widely used in areas of litigation apart from that arising from personal injury is final and binding arbitration, which eliminates the jury, simplifies procedure and substantially dispenses with appellate procedure.

A new form of partial alternative remedy is just now making its appearance in the field of automobile negligence, which is called the "no-fault" system. This provides generally for the injured person to receive certain limited compensation from his own insurance company without the necessity of proving that the injury was caused by the negligence of anyone, but to retain the right to seek certain additional liability compensation from another who caused the injury by his negligence.

In the field of medical malpractice a number of special alternative remedies have been tried. One is the screening panel for claims, usually composed of both lawyers and physicians. It attempts to make a preliminary evaluation of a claim, which is expected to encourage an early settlement. It does not attempt to make a final and binding determina-

tion of a claim. Although these panels have been in operation in various locations for some time, available information about their results has not yet been sufficient for an appropriate evaluation of their merits.

More recently, experimental programs for the final and binding arbitration of medical malpractice claims have been established. As yet these programs have not produced sufficient results to permit a reasonable evaluation of their usefulness. At least one program has been established for mediation of medical malpractice suits pending on a court docket. Although the results have been interesting it is not yet clear that this procedure provides a substantial remedy for the medical malpractice problems.

The foregoing alternative remedies, both those which have been applied in the medical malpractice field and those which have not, are interesting. On the basis of present information, the Commission is not in any position to recommend any particular alternative remedy. It is, however, highly appropriate that these and any other alternative remedies which appear to offer some benefit to the public should be tested in appropriate experimental programs.

The real core of medical malpractice problems, however, derives from the attempt of the legal profession to deal with the much larger and more complex problem of the financial needs of injured patients. This larger problem encompasses and greatly influences the narrower problem of the financial needs of only those patients whose injury was caused by the misconduct or substandard skill or care of providers of health care, which is the key legal factor of the medical malpractice problems.

It is, of course, the professional duty of a lawyer to do his very best, within the law, to solve the problems of his client. If a lawyer accepts an injured patient as a client, the lawyer is professionally obligated to try to obtain for the client the maximum amount of compensation allowable by law and to find some way, within the law, to establish liability of someone for payment of such compensation. The attorney is not subject to criticism for thus acting in the best interest of his client, provided that he does not engage in unlawful, fraudulent or unethical conduct in doing so.

In representing his client, the lawyer's only concern is the best interest of his client. He is not required to and should not permit concern over public welfare to interfere with advancement of the interests of his client. If the lawyer can, within the rules of law, achieve a benefit for his client, he has a duty to do so, even if that benefit might be detrimental to the public. It is the responsibility of the courts and of the legislature to give due consideration to the public welfare, in relation to the rights of the individual claimant.

If a lawyer can obtain compensation for an injured patient by persuading a court to adopt new legal rules of procedure, evidence or liability which makes it possible to impose liability upon a health care provider, the lawyer has a duty to do so. In changing legal rules, the court should give careful consideration to their effect on public welfare. Most often, however, there is no one before the court to speak for the interest of public welfare and there is not an adequate opportunity for the court to investigate the impact of legal rules on public welfare. Where the court fails to protect public welfare in establishing new legal rules, it then becomes the responsibility of the legislature to act in the public interest by correcting the rules established by the court.

The serious problems of the increasing frequency and cost of medical malpractice claims seems clearly to have arisen because of the zealous performance of these legal duties by lawyers representing injured patients as claimants. The efforts of the lawyers over the last ten years, at least, have resulted in changes in the rules of law which have made it easier for injured patients to recover substantial compensation from providers of health care under circumstances in which the injuries would not have been legally compensable under the rules of law which previously existed.

These changes in the rules of law were adopted by courts and are reflected in the reported court decisions throughout the United States. Their impact on the cost and frequency of claims, however, extends far beyond the few thousand reported court decisions.

Once a new rule of law is established by an appellate court, it is binding on all lower courts in the state. It affects their decisions which contribute to the cost and frequency of claims, even though those lower court decisions are not of-

ficially reported. Moreover, these new rules of law also affect even more numerous claims which are settled out of court or during trial. The total impact of a new legal rule, therefore, is much greater than would appear on the basis of reported decisions.

There are at least four clear examples of changes in legal rules which have made it possible to impose liability upon providers of health care under circumstances in which liability could not have been imposed prior to that change in the legal rule. In all four of these instances the change in rules has been virtually exclusive in its application to claims against providers of health care. The health care providers were thereby placed at a clear disadvantage in comparison with all other providers of personal professional services, especially in comparison with liability of lawyers.

The first adverse change is the "discovery" rule under the statute of limitations. It is the public policy, expressed in statutes of limitations, that legal claims should be disposed of within a short time after the claim arises. In personal injury litigation generally, the claim arises at the time when the injury occurs, even if the claimant is unaware of the injury, and the period of limitation within which suit may be filed starts at that time. In many states the period of limitations in claims against health care providers alone has been held to start not at the time of the injury but at the later time when the injury is discovered. This obviously leaves the provider of health care subject to suit for a virtually indefinite period and defeats the public policy purpose of the statute of limitations. In a few isolated cases the "discovery" rule has been applied to claims against lawyers. Otherwise it has not been applied to any other providers of professional services.

The second adverse change is the doctrine of "informed consent." In general personal injury litigation or other litigation arising out of the performance of personal services, there is no liability in the absence of fraud or misrepresentation for failure to warn another party of risks that may arise. In many states, however, the doctrine of "informed consent" is applied solely in claims against health care providers to impose liability, in the absence of any finding of negligence, solely on the basis that the provider failed to warn the patient of risks of injury before the patient consented to the health care. This rule subjects health care providers alone to afterthought claims. Even though a patient may have been given all the information he or she wanted to receive before consenting to a procedure, the patient, when confronted by the fact that he or she cannot obtain compensation for an injury unless he or she can claim that he or she wanted information about the risk of that injury and would not have consented if he or she had received that information, it is understandable that the patient might have a convenient lapse of memory. This rule exposes providers of health care to liability for patient injuries not caused by negligence, while other providers of professional services are not exposed to similar liability.

The third adverse rule is "res ipsa loquitur." This rule in its many variations permits imposition of liability for negligence in the absence of any direct evidence of negligence. Originally and traditionally the rule applied only to simple mechanical kinds of accidents, where common experience provided a basis for concluding that the accident would not have occurred unless someone had been negligent. Except in claims against health care providers this rule has never been applied in claims arising out of performance of professional services, because in such technical and complex matters common experience does not provide an adequate basis for determining whether an injury would not have occurred without negligence. The rule permits the imposition of liability on health care providers on the basis of speculation when no proof of negligence can be produced.

The fourth adverse rule relates to liability on the basis of an oral guarantee of good results. In claims arising out of the performance of any other professional services, no liability has been imposed for failure to fulfill a guarantee of good results unless the guarantee was in writing. Only in claims against health care providers has liability been imposed, in the absence of any finding of negligence, solely on the basis of an alleged oral guarantee of results which the provider denied having made. A rule of this kind is an open invitation to perjury and fraud to impose unwarranted liability.

These and other adverse new legal rules which

have been adopted during the period when the medical malpractice problems were developing to their present proportion are undoubtedly important factors contributing to the rapid increase in the frequency and cost of claims. This impact has been substantial regardless of whether claims were settled out of court or during trial or whether they were terminated at the trial court or appellate court level.

These adverse rules are inimical to the public interest. To the extent that they impose liability where none existed before and where none yet exists for other providers of professional care they contribute clearly to the increase in the cost of health care which is paid by the public either directly or indirectly. It is not only the providers of health care who suffer from the increased insurance costs but also their patients.

Even more important, the public, as patients, suffer from the fears and anxieties generated by these adverse rules. For the best possible health care, the relationship between the provider and the patient must be one of trust, confidence and good will. Changes in legal rules that impose greater legal risks on providers, especially legal risks for which there are no reasonable and effective safeguards, tend to disrupt the provider-patient relationship. If the law forces the provider to think of every patient as a potential claimant, the quality of health care necessarily suffers.

If the law requires the provider to always warn the patient of every frightening injury, however remote, that might occur in the course of his health care and requires this even if the patient does not want the warning but is willing to rely upon the professional judgment of the provider, many patients will be needlessly subjected to additional anxiety superimposed upon the existing anxiety over their illness. In many cases extreme anxiety on the part of a patient is likely to impede the success of his health care.

If the law permits liability to be imposed upon a provider on the basis of an oral guarantee of good results which are not achieved, the provider will always have to be on guard in communicating with the patient. Any expression of sympathy, encouragement or assurance to the patient could be interpreted, after the fact, as a guarantee of good results. To guard against liability, the provider would have to limit communication to the patient or perhaps communicate only in writing. Such blockage of communications is not likely to improve health care.

These and other new and adverse legal rules enable some patients to obtain compensation for injuries which would not otherwise be legally compensable but they are detrimental to the vast majority of patients who do not make compensation claims. Since health care is a matter of highest public concern, it is particularly unfortunate that these legal rules which have harmful consequences for all patients should be applied only to health care providers. These legal rules are not in the public interest. If they were, they should apply to all claims arising out of performance of professional services of all kinds, not exclusively to claims against health care providers.

Lawyers who represent injured patients cannot be expected to refrain from using these new legal rules as long as they remain in force or from seeking other new legal rules which will allow recovery of compensation for their clients. The courts must decide the cases presented to them and are unlikely to reverse a new legal rule once it has been adopted. It does not have the time or facilities to give adequate consideration to public interest. Where rules of law harmful to the public interest need to be corrected, the best and often the only way to achieve correction is through remedial legislation.

Uniformity of law is often, but not always, desirable. The adverse legal rules discussed above are not, at present, uniformly applicable in all states. The welfare of the public, as patients, would be even more adversely affected if these rules were uniformly applied in all states. If appropriate remedial legislation were developed, however, to correct these adverse rules of law, it might be desirable that they be uniformly adopted in all states.

Recommendations 8, 9 and 10

8. States should adopt remedial legislation to correct adverse legal rules of liability, procedure and evidence which apply only in liability claims against health care providers including but not limited to (a) the "discovery" rule under the statute of limitations, (b) the

doctrine of "informed consent," (c) the application of the doctrine of "res ipsa loquitur" to injuries arising from performance of professional services, and (d) the rule allowing liability based on an "oral guarantee" of good results. These and similar legal rules are disruptive of and inimical to good health care for patients.

9. Courts and bar associations should give careful consideration to the establishment of rules regulating contingent legal fees, with special attention being given to the establishment of a decreasing scale of percentage fees in multiple steps relating to increasing levels of monetary recoveries by clients.
10. Health care providers, the legal profession, the insurance industry and consumer organizations should be encouraged to thoroughly investigate the merits and benefits of alternatives to the present court litigation procedures for handling compensation claims against health care providers, including the establishment of appropriate pilot programs when appropriate. Such investigation should include both existing procedures, such as screening panels, contractual arbitration, and mediation, and any other procedures which appear to offer a likelihood of beneficial results for the public welfare.

Health Care Providers

The medical malpractice problems became manifest in sufficiently critical degree to require the establishment of this Commission because of the concern of and about the health care providers. The central element of this concern revolved around the rapidly rising cost of liability insurance for the providers and recurring episodes of difficulty in obtaining insurance coverage. Since the costs of insurance, like any other cost of providing health care are necessarily paid out of the fees and charges paid directly or indirectly by the patients, the concern is one about the cost of health care to patients.

Problems of availability of insurance coverage also threaten the welfare of patients. If a provider of health care were unable to obtain adequate liability insurance it would be unwise to continue to provide patient care. This would reduce the amount of care available to patients. So far, problems of coverage have been local and temporary. They could become more general and of longer duration. Such problems typically arise when insurance companies find that premiums collected are outpaced by losses.

The rapid premium increases and the coverage problems which have occurred in recent years have been the result of losses which have greatly exceeded the actuarial expectations based upon projections of past experience. The increasing losses are the result of an increasing frequency of claims and a higher average cost of claims, including both compensation paid and litigation expenses.

The providers of health care are seriously disturbed by this frightening paradox of the medical malpractice problem. Although they know that the general quality of health care is higher than it has ever been before and is continually improving, they are confronted with the inexplicable experience of increasing losses and increasing insurance costs. It thus appears to the providers that no matter how great the improvement in the quality of care, further increases in the loss experience seems inevitable. This is extremely frustrating for providers of health care, who are dedicated to improvement of quality.

Health care providers, by training, tradition and temperament have the primary goal of curing the sick and disabled. Nothing is more disturbing to a provider than failure to achieve beneficial results for a patient. This is especially regrettable to the provider who knows that the adverse result may be due to an inadvertent departure from the accepted standard of skill and care.

When a patient suffers an adverse result, the first instinct of the provider is to do everything possible to remedy the situation. If concern about legal liability is injected, however, the occurrence of a poor result is apt to make adversaries out of the provider and patient. This disrupts the harmonious provider-patient relationship which is essential for good health care. If a claim is made, the relationship is usually totally destroyed and the patient seeks future care from another provider.

Liability insurance should help to minimize this disruption by protecting the provider from economic loss. However, when insurance costs are

rapidly increasing and when continuing availability of coverage is uncertain, a claim or a threat of a claim is likely to be highly disruptive of the provider-patient relationship. The fear of loss of insurance coverage or increases in insurance costs is unlikely to have a result beneficial to patients.

Although the problems of medical malpractice may seem, on the surface, to be exclusively problems for the health care providers, they are essentially problems which threaten the welfare of patients. The problems must be solved in the interest of the public who are the patients.

Recommendation 4, 5, 6 and 7

4. Providers of health care should be encouraged to voluntarily participate in effective continuing education programs and to voluntarily submit to appropriate periodic reevaluation of their professional competence. Compulsory requirements for continuing education or periodic reevaluation should not be applied to health care providers unless they are equally applied to all licensed professions.
5. Appropriate state legislation should be adopted to permit prompt protection of patients from risks of injuries arising out of exposure to services of health care providers whose dangerous deficiencies in professional competence have been clearly established, but health care providers should be fully protected by due process of law from unjustified interference with their professional practices.
6. For protection of patients from unwarranted risks arising out of medical research, such research should be conducted only in conformity with the standards established by the Declaration of Helsinki and the Ethical Guidelines for Clinical Investigation adopted by the American Medical Association.
7. Appropriate state legislation should be adopted to restrict independent health care practitioners licensed to offer services to patients for compensation to those whose practice is based upon education, training and experience in scientific health care and who are graduates of approved schools of such scientific practice accredited by a recognized national educational accrediting organization or whose equivalent education is established by appropriate tests.

Injury Prevention

The most obvious way to minimize the problems of medical malpractice is, of course, to reduce the frequency of injuries suffered by patients in the course of their medical care, regardless of the cause of the injury. We agree that any appropriate proposals aimed at accomplishing this objective are highly desirable.

Even though the percentage of physicians who participate in continuing education programs is very high, and even though the quality of continuing medical education programs is excellent, there is always room for improvement in both participation and quality. Such improvement on a voluntary basis should be encouraged. If continuing education is made compulsory for physicians, however, there is just as much reason to make it compulsory for members of all licensed professions.

Even though the level of professional competence among physicians in the United States today is generally very high, there is also room for improvement. Periodic reevaluation of professional competence of physicians on a voluntary basis should be encouraged. If periodic reevaluation of professional competence is to be made compulsory for physicians it should also be made compulsory for all other licensed professions.

Despite the generally high level of professional competence among physicians in the United States today, there are a few physicians whose professional competence is so deficient that their licenses to practice medicine should be revoked, suspended or limited unless or until the deficiencies can be eliminated. Similarly, there are a few physicians whose hospital staff privileges should be revoked, suspended or limited because of professional incompetence, unless or until their deficiencies can be eliminated.

The right of all physicians to the protection of due process of law in proceedings for revocation, suspension or limitation of their licenses or their hospital staff privileges must be preserved, but legal procedures need to be improved to provide expeditious methods for protecting patients from the risks of those who are in fact lacking in profes-

sional competence. In this regard, however, it would be totally irrational to eliminate from patient care physicians trained in scientific medicine because of deficiencies in their professional competence while at the same time permitting unscientific practitioners, such as chiropractors and naprapaths, who are totally lacking in competence to provide scientific medical care to undertake any patient care.

Improvement in continuing medical education, periodic reeveluation of the professional competence of physicians and more effective enforcement of medical licensure law should eliminate some instances of injuries caused to patients by substandard care. Not all instances of substandard care, however, are due to lack of professional competence which might be corrected by continuing education or reevaluation or forestalled by license revocation. Being human, even the physicians with the highest professional competence can err occasionally and provide substandard care which results in an injury. Even with the best possible efforts toward continuing education, professional reevaluation and licensure regulation many injuries to patients in the course of health care will continue to occur, some of which will be caused by substandard care and more of which will be unavoidable.

We believe, however, that the frequency of injuries to patients in the course of their health care can be substantially reduced by effective injury prevention programs established in every hospital. Such programs would require the active cooperation and support of all of the health care team who provide care in the hospital. An appropriate hospital committee, designated a patient care committee perhaps, could identify the kind of injuries that occur, the severity of the injuries, the circumstances in which they occur and the frequency with which they occur. The committee could then develop procedures to reduce the risk of such injuries, especially those of greater frequency and severity. It would not, of course, be possible to eliminate all injuries, but it seems likely that they could be substantially reduced.

To encourage hospitals to establish such injury prevention programs, it would be necessary to give proper protection to the confidentiality of such activities so that the reports, deliberations and activities of the committee would not be subject to discovery or admissible in evidence in litigation or subject to disclosure in the press. This would not bar any claimant from hospital or medical records now available to him for purposes of litigation.

Recommendation 2

Hospitals and other appropriate institutions should be encouraged to establish appropriate patient care committees for the purpose of reducing the frequency and severity of injuries suffered by patients in the course of their health care and the activities, proceedings, records and reports of such committees should be confidential and protected by law from discovery or admission in evidence in any legal proceeding and from publicity in the news media.

Patients' Rights

Since the paramount concern of the Commission is the welfare of the public, especially as patients, it is essential to establish what the rights of patients should be in relation to health care. A patient has the right to expect a high quality of health care of the kind and frequency adequate to meet his or her health needs and at a reasonable cost. The patient has a right to be protected from exposure in the course of health care to risks of harm relatively greater than the risks of harm arising out of his or her health condition for which care is sought.

The patient has a right to reasonable compensation for injuries caused in the course of health care by misconduct or substandard skill or care on the part of a provider of health care without unreasonable delay or expense. The patient has a right to be protected from increases in the cost of health care resulting from unwarranted increases in the expenses of health care providers, such as increasing insurance costs caused by unwarranted claims for compensation for injuries not caused by misconduct or substandard care.

A patient has a right to expect the benefits that can be achieved only by scientific medical research, which necessarily involves clinical investigation with human subjects. Both patients and subjects, however, have a right to be protected from unreasonable risks not commensurate with the

anticipated benefits to them personally and to the general public. The patient has a right to be protected from any of the risks of clinical research unless they have consented to participation with knowledge of the unproven investigational nature of the procedures. Where patients are incapable of giving consent they should not be subjected to risks of clinical research except under special circumstances with special safeguards to protect their interests.

A patient has a right to expect his government to protect him from risks arising from health care provided by independent practitioners who are unqualified by education, training and experience, based upon scientific medicine, to make differential diagnosis of a patient's health status and to apply scientifically accepted therapeutic procedures. Such unscientific practitioners expose patients to greater health risks than would arise from scientifically trained practitioners, even those at a low level of professional competence.

A patient has a right to receive comprehensive information from any provider of health care about his or her health status including the risks arising therefrom and the risks of any proposed health care procedure, to the extent that the patient requests that information. An attorney for any patient, with the consent of the patient should have the right to inspect the hospital records of the patient and to copy all or any part thereof to the extent that the attorney deems necessary to protect the legal interests of the patient without necessity for first filing a lawsuit.

The problems of a patient's health are not always matters within the control of providers of health care. Health of patients depends upon nutrition, environment, housing, education, sanitation and other social and economic factors as well as health care services. Particularly among disadvantaged patients these non-provider causes of health problems are often overwhelming. Providers of health care alone cannot correct these causes of health problems.

Most patients realize that some illnesses in some circumstances are beyond the ability of health care providers to produce a cure. Most patients also realize that every health care procedure, even with the best of skill and care, unavoidably involves some risk of an injury or an unsatisfactory result.

An injured patient, however, is often confronted with an urgent need for financial assistance. Unless that need is met from some other source, the patient may be virtually compelled to seek compensation through a claim against a provider of health care. The patient, in these circumstances, is unable to determine what caused his injury or whether it is legally compensable, but must rely upon the legal profession for guidance in such matters.

Where the nature of the injury is such that it would justify a substantial amount of compensation, if it is legally compensable, attorneys are likely to try very hard to find some basis for imposing liability. Because of the desparate need of the patient, in some instances courts tend to change the rules of liability to provide compensation.

The need of an injured patient for financial assistance is just as great whether the injury was caused by medical malpractice or whether it was an unavoidable result without fault on the part of anyone. If this need were met in those cases in which the injury was not caused by medical malpractice, the cost of legally compensable injuries would probably be greatly reduced.

We believe that injured patients whose injuries were not caused by medical malpractice should have available to them some source of financial assistance. This might be private insurance, an employment welfare program, a private welfare program or some form of governmental assistance which would provide reasonable compensation. If injured patients were given the option of receiving such compensation from any of such sources rather than making a liability claim, it seems likely that the frequency of liability claims would diminish.

Recommendation 3

The right of a patient upon request to receive comprehensive information about his or her health status, including risks and probable consequences of current health conditions and the risks and probable consequences of any proposed health care service or procedure should be recognized.

No-Fault Compensation

The economic needs of patients injured in the

course of their health care is just as great regardless of whether the injury was caused by malpractice or whether it was an unavoidable risk inherent in the care. The concept that an injured patient should receive compensation for his injury without the necessity for litigation, the expense of legal representation and the necessity for proving malpractice is, therefore, quite attractive. This is essentially the concept involved in proposals submitted to the Commission for "No-Fault Compensation of Medical Injuries."

There are at least three possible types of no-fault systems: (1) Self-insurance against the risk; (2) Compulsory group compensation insurance; and (3) Strict liability insurance. For each type there are many variations coverage, sources of funds, and methods of administration.

Self-insurance would contemplate that each person would purchase insurance against his own loss. Many already have such insurance in a variety of ways. Health insurance already covers, at least partially, the additional cost of care which arises from a patient injury. Disability or income replacement insurance for those who have it, provides at least a partial compensation for loss of earnings resulting from a patient injury. Accident insurance may pay for death, loss of a limb or eye or other member. Life insurance pays for death.

Those who have this kind of insurance protection already have some source of economic aid to meet the needs which arise from a patient injury. For this reason, they may be less likely to make a malpractice claim, although there is no available statistical data to show to what extent, if any, this is true. Moreover, under existing law the collateral source rule does not allow an offset for such insurance benefits against damages recoverable in litigation. For example, an injured patient who was able to prove malpractice could recover damages for necessary additional hospital care, even though the care had been fully paid by hospitalization insurance.

Most self-insurance type no-fault proposals would, at least, contemplate that insurance benefits received would be offset against damage awards. Some would prefer that the insurance benefits be the exclusive source of compensation, although that would involve serious legal problems. Litigation would be virtually eliminated in relation to the insurance benefits, except in a few disputed questions of coverage.

One form would be a hospital admission insurance, similar to "trip insurance" which a patient would buy when he enters the hospital. This would allow the patient to decide for himself what maximum level of compensation he wanted to establish. The overhead cost of this kind of insurance, however, would be very high. Since the patient pays the cost eventually anyhow, it would probably be more economic for the hospital to buy the insurance. This would also help to avoid the effects of the collateral source rule.

A compulsory group compensation insurance would be a program similar to workmens compensation in which someone is required to provide insurance which will pay certain benefits to injured patients regardless of whether the injury was caused by negligence and would eliminate the right of the patient to recover damages on a tort liability basis. The easiest way to accomplish this would be to extend the workmens compensation law to include compensable medical injuries. It could also be accomplished by requiring all hospitals to provide compensation insurance which would cover all hospitalized patients. Another alternative would be to require such compensation coverage to be included in all health insurance or health service programs.

The major difficulty with this type of program is the problem of identifying a compensable injury. Every patient who seeks medical care and especially those seeking care in a hospital is already suffering from some injury, illness or deformity which does not arise out of the health care. These should not be compensable under a patient injury compensation system. Where some illness, injury or deformity remains after the completion of health care, it may be the natural and unavoidable consequence of the patient's condition which led to the health care. These also should not be compensable under a patient injury compensation system. After the completion of health care, however, there may be some new or remaining illness, injury or deformity which is not the natural and unavoidable consequence of the patient's original condition. This would be appropriately compensable. The difficulty arises in trying to draw the lines which would identify

compensable injuries arising in the course of health care.

Because of this difficulty it is likely that the necessity for much litigation would remain, even though litigation of malpractice liability would be eliminated. Workmens compensation litigation of questions of coverage, such as this, has been quite extensive, although not as extensive as personal injury tort litigation. Since patient injury coverage questions would be more difficult to determine than questions of coverage of employment injuries, it is likely that there would be more litigation than there is under workmens compensation.

Since accurate statistics do not exist on the frequency and severity of compensable patient injuries it is not possible to make an accurate estimate of the cost of this type of program. Assuming benefit levels approximately the same as those provided under workmens compensation, however, knowledgeable representatives of the insurance industry have estimated that the total cost of this type of compensation program would be three or four times the present total cost of liability insurance in the health service field.

It would be possible, of course, to develop a program which would not attempt to provide benefits for all patient injuries but would provide benefits only for catastrophic injuries, such as those which result in death, permanent disability, or loss of a limb or organ. This limitation might reduce the total cost of this type of insurance.

The strict liability type of program would contemplate that insurance coverage would be purchased by health care providers, although it would be ultimately paid by the patients as a part of the cost of health care. This is the type of no-fault insurance carried by producers or distributors of products. If the product is defective and because the degect causes an injury, the injured person is able to recover unlimited amounts of compensation without the necessity of proving that the injury was caused by negligence. The amount of compensation is not limited, but is determined by the standard measures of damages applicable in tort litigation.

This type of program would be the most costly and would place the financial burden directly upon the health care field, where it would be added to the cost of health care eventually paid by the patients. The courts, in adopting new legal rules making it easier to impose liability upon health care providers, are moving in the direction of strict liability. If this trend continues unchecked, providers will eventually be held liable for whatever compensation the courts and juries see fit to award for every injury which arises in the course of health care, whether caused by malpractice or not. Based on experience in the products liability field, litigation would not be diminished and proportionate legal expenses including attorneys' fees, would be likely to increase. If health care providers were able to obtain insurance against this greatly increased risk, the premium cost would necessarily result in substantial increases in the cost of health care.

All three types of no-fault systems are subject to many variations. Only the compulsory compensation type, which is similar to workmens compensation, offers an opportunity to provide controlled levels of compensation for patient injuries, whether caused by malpractice or not, without adding to the cost of health care. Indeed, if tort litigation were eliminated, as it is under workmens compensation, this type of program could help to reduce the cost of health care.

As the best way of spreading the cost of this compensation system, all employers could be required to provide the insurance protection for all of their employees and for all unemployed dependents of such employees. This would provide almost universal coverage. The few persons who would not be covered by such employer insurance program could be provided similar benefits through a governmental welfare program. The substantial cost of the program would not be a burden imposed upon the sick and injured through an increase in the cost of health care, but would be spread equitably among everyone, through the price of the goods or services sold by the employer.

The Commission does not have the knowledge, expertise or time to draft a detailed program for such compulsory compensation insurance type of no-fault compensation or to work out all the problems it is likely to involve. It does, however, believe that a program of this nature is worthy of study, investigation and testing.

Recommendation

The Committee recommends that one or more

state governments should study and investigate, by all appropriate means including pilot programs, the feasibility of establishing a compulsory patient injury insurance program to be provided as a benefit of employment, similar to workmens compensation insurance, to provide designated compensation benefits for injuries arising from health care whether caused by medical malpractice or not, in lieu of tort law liability.

Separate Statement of James E. Ludlam, J.D.[3]

I share the frustration of my fellow Commission members in the precipitate termination of the Commission deliberations with the premature filing of the Commission Report. For this reason I specifically join in the Separate Statement filed by Mr. Howard Hassard and express great sympathy with the Separate Statement filed by C. A. Hoffman, M.D.

As a Commission we failed to even approach an overall solution of the malpractice crisis. We did for the first time quantify the problem and indicate the continued trend (all adverse to the providers). We did dispel many of the myths that have developed. However, we failed to analyze and make any basic recommendations on the important contributions being made by the group programs sponsored by the various state and local medical and hospital associations that have emphasized the very preventive programs that are emphasized by the Commission. These group programs are the hope of the future. Unfortunately, the research upon which such analysis could have been made by the Commission was received too late to be an agenda item and, therefore, was not made a part of the final Report.

Also, little emphasis has been placed on the overall trend in malpractice claims against the professionals such as lawyers, architects, accountants, and engineers, all of whom are increasingly being troubled by the traumatic experience of being challenged by their respective clients. The challenging of a man's professional competence is far different than challenging his ability to drive his car or maintain his sidewalk.

When I accepted an appointment to the Commission I was convinced that the solution to the medical malpractice problem, to the extent it could be solved or minimized, did not lie with the federal or state governments or with the insurance industry, but only with committed leadership by the health care providers themselves on an aggressive basis. Nothing that I learned as a result of the Commission deliberations has changed this viewpoint. There are no miracles or instant solutions.

So long as we permit the individual physician to be the target of the errors and defects in the health care system we are going to have a medical malpractice crisis. Fundamentally, we must provide a new mechanism for compensation of the patient who has suffered injury as the result of malpractice or ultimately for a bad result. Under the present system we attempt to solve this problem under a tort adversary system. However, an individual who is injured by his employer is compensated under a workmen's compensation system, a person injured by an automobile driver may be compensated by a no-fault system, an individual suffering illness is taken care of by health insurance. The government now provides compensation for cost of illness to the aged and the poor without a tort mechanism. We, therefore, find that malpractice litigation as a method of problem solving is not only extraordinarily expensive, inefficient, and most erratic in its solution, but is also not in accordance with modern trends of injury compensation.

Ultimately we must develop a system of patient compensation based upon a sharing of responsibility by the entire health care system or the entity furnishing the finances for the health system—not by the liability of the individual physician. Improved quality of care leads to a higher standard against which potential liability is judged. The members of the medical profession should not be penalized for improving standards of care.

The AMA, the AHA, and AOA must now face up to the fact that the solution to the malpractice crisis is back in their respective laps. None of the organizations can meet it alone. The Commission research, far more than its findings and recommendations, can furnish a basis for constructive action. However, the AMA, AHA, and AOA cannot be

[3] See also concurrence with entire statement of Howard Hassard.

effective without a far greater commitment by their respective constituents to an overall solution involving sacrifice of individual prerogatives for the common good.

Separate Statement of Richard M. Markus, LL.B.[4]

This Commission undertook a most difficult task. Its charge as prescribed by the "Statement of Formal Determination" covered an extremely broad range of subjects relating to health care, health care providers, health care provider neglect, and health care provider insurance. Despite the multiplicity and complexity of issues the Commission attempted to consider most germane matters. Limitations on the personal time of some Commission members and limitations on the total time for the Commission life may have made it difficult to consider all of those issues with the in-depth approach that could conceivably be helpful. Nevertheless, the results obtained represent a reasonable synthesis of available information and conclusions which do merit careful consideration by all concerned.

The merits of the conclusions rest largely in the orientation that was adopted by most of the Commission members—the interests of the patient-consumer-public is paramount over interests of health care providers, lawyers, or insurance factions. It must be remembered that approximately three-fourths of the Commission members were themselves health care providers, lawyers for health care providers, or insurers for health care providers. Despite that heavy weighting of the Commission in favor of persons with a predisposition to favor the health care provider in a dispute with the patient-consumer, most Commission members tried to accept their responsibility objectively. At the same time, readers of this report should understand that occasional lobbying efforts were made to assemble the allied interests of those predisposed to special favor for the health care provider. At least one staff member for a professional health care association made regular appearances at the meetings, undertook to persuade Commissioners on certain issues, and actually prepared language for submission to the Commission through one of the members of the Commission. For the most part, those efforts were unsuccessful because most members of the Commission held true to their goal of objectivity and fairness to the patient-consumer.

There were a few instances, in my judgment, where the Commission failed to give the patient-consumer sufficient consideration. Therefore, in addition to my joinder in certain separate statements of Commissioners dealing with such matters, I would add remarks on the following narrow topics:

Qualified Immunity In Hospital Emergencies When the Doctor Calls For Help

In these two sections of the Commission's report, the Commissioners struggled with legal issues which were not entirely familiar to some of the Commission members. Regrettably, the resulting language approved by the Commission probably does not convey the intention which the Commission sought to communicate. The language actually adopted by the Commission itself calls for "qualified immunity" from civil liability for special emergency rescue teams in hospitals and health care personnel who respond to emergencies arising from unexpected complications in the course of treatment rendered by other health care personnel. Apparently because of the confusion in the minds of some Commissioners, the term "qualified immunity" was never defined.

The debate on this matter seemed to show that a majority of the Commissioners might oppose legislation that rendered health care personnel immune for their own negligence in an emergency situation or in treating unexpected complications arising out of the care by another provider. They may have had some difficulty in understanding or accepting the usual concepts applicable in most legal jurisdictions that a health care provider is "immune" from civil liability if he acts with reasonable care in the emergency circumstances which were not of his creation. In those circumstances, he is traditionally held only to the standard of care of a person with

[4] See also concurrence with statement of Norma Almanza on access to medical records; concurrence with entire statement of Ella Strother; and concurrence with statement of Monroe Trout on medical licensure.

similar training as himself who is faced with precisely the same emergency. He is not expected to act with qualifications beyond those he possesses or to act in the fashion he might be able to do when there was adequate equipment and adequate time for careful judgments.

The present language adopted by the Commission would on its face suggest some kind of immunity for a physician who negligently amputates a healthy leg which he carelessly mistook for the diseased extremity after an unexpected lesion had developed on the diseased limb during the care of a prior physician. Certainly, this cannot be the intention of the Commission. The patient-consumer is entitled to more protection. The Commission found that the so-called good samaritan statutes serve no valid purpose. These new proposals are equally unjustifiable.

The Contingent Legal Fee Defense Costs Are Part of the Problem

My comments on these matters are intended as concurring opinions rather than dissenting opinions. The present language of the Commission report omits certain relevant considerations which should be reviewed. There are irresponsible lawyers, just as there are irresponsible doctors. Unreasonable and unjustifiable legal fees may have to be curtailed publicly if the legal profession fails to regulate them. However, the justification for regulation of legal fees should never be the cry that high legal fees charged to the patient are offensive to the physician. The Commission's study has seemingly put to rest the myth that contingent legal fees cause or contribute to cause unreasonable malpractice litigation. However, the paramount interest of the patient-consumer does justify regulation of legal fees if and when excesses exist. Defense legal fees must be treated in precisely the same fashion, since we have been told repeatedly that the patient-consumer pays the health care bill and thereby absorbs the malpractice insurance premium with the defense legal fees which it incorporates.

The Commission recieved no hard data as to the frequency or amount of excessive legal fees, although we did hear a few anecdotal episodes which may indicate excessive fees in a few circumstances. This is a matter which is best resolved on a local level to meet local problems. The staff language supplementing the Commission action refers to the somewhat different fee schedules adopted in New Jersey and New York City. These may or may not be good examples, as local circumstances should dictate. Further, the governing authority should retain some flexibility to require lower fees in some instances and to authorize higher fees in others, in order to provide equity to the parties litigant and their lawyers.

Finally, we should remember that excessive zeal in curtailing legal fees will produce the very result we all seek to avoid. If lawyers are forbidden satisfactory payment for services in this narrow legal area, they will tend to avoid representation in that legal area. There are already many lawyers who will refuse to undertake any professional liability claim because of its complexity, its expense, its risks, and the likelihood of antagonizing physician-witnesses in far more common personal injury situations. When insurers cannot obtain a sufficient profit margin in the malpractice insurance market, they will withdraw from that market. When lawyers cannot obtain sufficient fees in malpractice representation, they will withdraw from that representation.

Malpractice cases represent an extremely small fraction of personal injury claims, so lawyers trained in these areas could abandon this field completely without any significant financial detriment. In most areas, the regulation of the market place is the most efficient regulation. Governmental regulation of legal fees must be undertaken with caution in those areas where it is deemed necessary.

Compensation For Medical Injuries

Lack of time to absorb contractors' studies and lack of time to debate probably prevented the Commission from taking more definitive action on this subject. There were some who hoped to find a panacea by which all "medical injuries" would be fully compensated regardless of fault without increasing the cost of medical care. On its face, that goal is unreachable.

At the outset, the Commission members wrestled with the virtually impossible task of defining the "compensible event" which results from a "medical injury". Every effort to date on

this subject has met with the same lack of success. Although we have a reasonable understanding of the terms "work injury" and "automobile accident injury", we have no real mental picture that covers the field of medical injuries. Does a "medical injury" occur when a physician fails to heal his patient or fails to heal him quickly, in the face of the joint hopes by the physician and the patient that an early recovery can be obtained? Illness and accidental injury become inextricably intertwined when fault issues are ignored.

However, when attempts were made to select an arbitrary definition of "medical injury" (which definition was vigorously attacked by some physician members of the Commission as totally unreasonable), some concept of the staggering costs for such a compensation system was unveiled. Studies by contractors for the Commission suggest that at least 150 "medical injuries" occur in a hospital situation for every single claim that is made. That study assumed a definition for "medical injury" which was considerably narrower than those used by reformers who really seek to compensate everyone sustaining damage as a result of the inadequacy of medical care given to them. Recognizing that only 41% of those who make claims now receive any compensation, this would still mean that the number who must be compensated under a general compensation system would be more than 350 times the number who are now compensated. When we remember that more than half of the people now compensated receive less than $3,000.00, it is doubtful that any significant reduction in the amount of payments can be equitably accomplished. However, even assuming that there were some substantial reduction in the amounts paid to the average injured patient, it is clear that the costs of the system would be several hundred times the cost of the present system.

Proponents of a generalized compensation system (sometimes called a "no-fault" system) would hope to hide the costs by pretending that they are not costs of medical care. Instead, they would seek to shift the costs to some other system of payment by persons not immediately involved in the health care process (e.g., taxes). That shift does not change the cost factor, it only pretends to hide the true costs. This situation contrasts markedly with the automobile compensation proposals which seeks to pay twice as many people, while paying each person approximately half what he would presently receive—thus not changing materially the total costs. Without regard to the wisdom or equity of any of these proposals, it seems clear that the cost considerations for a medical compensation plan are unacceptable to our society.

Of course, a generalized publicly supported health insurance program would provide part of this remedy. Under such a program, the medical costs for illness or injury (regardless of source) would be paid from a generalized tax base. This would still leave unresolved important items of compensation for income impairment, disability, disfigurement, dismemberment, and human suffering. A greater opportunity to study the practicalities of such a generalized compensation plan might well have permitted the Commission to put that myth at rest, just as it has destroyed other myths in the medical malpractice field.

Separate Statement of George W. Northup, D.O.[5]

The Final Report of the Secretary of HEW's Commission on Medical Malpractice

In my opinion, failure to permit the membership of the Commission on Medical Malpractice a chance for final review and refinement of its report jeopardizes the authenticity and accuracy of that report. Twenty-one commissioners spent countless hours of meetings, studying reports and formulating opinions. They did not deserve denial of completing their work.

Research reports were received *after* the final report had been completed. Some research reports have not yet been finished—much less recorded. Time has been granted them. Why not the Commission?

Our time schedule was further delayed by the Commission's desire to hear from the public sector through public hearings. We did this before considering a single resolution. Is our penalty for seeking to understand the American public's response to the malpractice problem wrong? Are we

[5] See also concurrence with entire statement of Howard Hassard.

being penalized because we sought this information?

The December 31, 1972, deadline was placed upon us with little, if any, consultation with the Commission itself. Some of us received the final draft of the report less than five days before submission to the Secretary.

The record will show that the Commission took its charge seriously. Attendance at Commission meetings was high. Rarely were there more than three commissioners absent from any one meeting.

The report was not easy to write. Many of us on the Commission will always feel that the report might have been better if all of us had had the opportunity for final study and possible revision of some of the text.

The Commission staff and writers accomplished an almost impossible task overnight. They merit our thanks for without them there would have been no report.

But if some of us had realized that the major objective of the Commission, namely problem-solving, was to be superceded by the goal of speed, then some of us would probably have been less zealous and devoted to our task.

It is too bad that the Commission comes to the end of its period of service dissatisfied because of events beyond its control.

Separate Statement of Ella L. Strother[6]

The Consumer

That acts of medical malpractice exist cannot be denied by any knowledgeable person. The Commission has heard complaints of improper procedures, inadequate diagnosis and/or treatment, absentee medical personnel during delicate operations, failures in communications and other acts of malpractice.

Whether defensive medicine is a fact or fiction depends largely upon the interpreter of the procedures.

There needs to be re-evaluation of the definition of medical malpractice. Health consumers and health providers should be in total agreement with the components included in this definition. This knowledge should be circulated widely and should be accessible to all health providers and consumers.

Many acts of medical malpractice have led to medical injuries to the patients. If the number of medical injuries can be reduced, then incidents of malpractice and the legal suits, which sometimes accompany them, would be reduced. The overwhelming majority of former patients or guardians who appeared before the Commission with grievances against health providers stated that they did not or had not wanted to institute a law suit against the health providers concerned. Legal redress was a last resort when the lines of communication broke down. The patient had no other recourse in obtaining the truth about his condition or just and equitable compensation for the hurt, damage, or wrong inflicted upon him.

There is no set method or course of procedure whereby individuals become aware of an injury or acts of medical malpractice. Neither is there a definite time, in all cases, for an injury or acts of medical malpractice to manifest themselves.

A few patients become aware of medical injuries through the work of their doctors. However, many patients testified about their inability to gain information from the health provider or to obtain testimony from one health provider against another health provider. There is no doubt that many health providers refuse to communicate with the consumer.

While most health providers still enjoy a high degree of respect and appreciation from patients and the general public, the God-like image of health providers, particularly doctors, is fast being accepted for what it is—erroneous. Consumers, all over the country, view doctors in a proper mortal prospective. As mortals, they are capable of errors and other human shortcomings. However, increased numbers of Americans know that many of the improper procedures which lead to medical injury or damage need not exist.

Doubts and undue prolonged pain after medical treatment have caused patients to delve into their cases more thoroughly. Gathering needed information frequently has been unduly costly to the patient or his guardian in terms of money, anxiety,

[6]See also concurrence with statement of Monroe Trout on medical licensure.

and body fatigue. Nevertheless, the patient only seeks the truth to attest to the quality of health care he has received.

The majority of the consumers recognize many of the good facets in our present health care stsyem. At the same time, these consumers recognize the many deficiencies in our present health care system which result in pain, suffering, and sometimes death. Many of these deficiencies need not exist. Large numbers of consumers are requesting changes which will eliminate or decrease the deficiencies and medical malpractices. At the same time, they are requesting improved quality care and accessibility of health care goods and services for all Americans.

The Consumer has become quite knowledgeable about the health care system as a whole. Relevant changes in school curricula, inexpensive publications, newspapers, radio, and television have fostered timely information to the consumer. His right to attend professional conferences has been exerted. However, the consumer's main source of knowledge has been gained through his own participation in policy-making bodies established by such government agencies as HEW and OEO. "The establishment and operation of comprehensive service programs must involve, from the beginning of planning and throughout the conduct of the project, all appropriate elements of the community that share the programs' objective and interest."[7]

To show that the consumer is important in planning his own destiny, the guidelines of OEO further state, "The poor not only need help, but must help themselves. Programs for health services, like all components of community action programs, must be developed, conducted, and administered with the full and active participation of the persons served, to the end that the program becomes truly responsive to the needs and wishes of those it is designed to serve."[8]

Increased numbers of consumers believe that they can improve the health care system and help to eliminate many of the shortcomings by being an active participant in a senior partnership with the present entities which now control or have an active interest in promoting quality health care and education for all Americans.

Consumers have recommended that the folowing items be given highest priority for consumer concerns:

1. The right to participate as an equal component in all levels of the health care system. It is not enough to include consumers on advisory panels, committees, or boards. Consumers must be a meaningful part of policy and decision making boards or bodies.
2. The right to a patients' bill of rights, respect for the person, abilities and capabilities of all human beings. Rightly or wrongly, many consumers complain of wrongs inflicted upon them through improper medical procedures, through the promotion of scientific advancement, and lack of medical care.

   The consumer requests that a patients' bill of rights be developed in all health care institutions, programs, and services. This bill would protect his right to know procedures he has to undergo and to provide access to the medical information which concerns him. Moreover, this bill would protect his person from scientific abuse without his permission or knowledge for the purpose of scientific advancements or medical provider training.
3. The right to quality comprehensive health care for all Americans.

   Many Americans do not have access to the health care system. This leads to no treatment or inadequate treatment for many Americans. It is true that the number of health providers in the country has increased but this is due largely to the importation of foreign health providers. Many consumers believe, and rightfully so, that they are capable of being trained as doctors, paraprofessionals, and in other areas of the health care system. The major deterrents are acceptability and finances. Additionally, they not only believe that they would adequately fill the vacuum in the present health care system, but the medical needs of a greater number of the socioeconomic groups would be better served. Therefore, this group of consumers requests that training institutions be more receptive to all socio-economic groups, par-

[7] OEO Guidelines.
[8] OEO Guidelines No. -6128.1, March, 1970, p. 4.

ticularly the socio-economically deprived groups which in the past have been excluded or accepted in token members only.

To be meaningful, quality health care must be available, accessible and acceptable. Therefore, the consumer and all concerned parties have suggested that Congress act with deliberate speed in acting upon pending legislation to carry through said recommendations.

[The foregoing statement is concurred in by Richard M. Markus.]

Separate Statement of Monroe Trout, M.D., J.D.[9]

Medical Licensure

I dissent from the majority position on Medical Licensure, not because I am in disagreement with some of the concepts which are embodied in the majority positions, but because I believe that it is time for national licensure of physicians. Even though I strongly believe in States Rights, I think that medicine can best be served in the United States by having physicians licensed by a National Board of Medical Licensure. This Board need not be controlled by the Federal Government but could be a non-profit foundation type operation or a body similar to the National Academy of Science.

First, I believe that it is unnecessary to examine a student who has completed a satisfactory medical education in an approved American Medical School. There is something wrong with a system which permits the denial of a license as a result of one written examination when that same individual was frequently examined orally, but written test and clinically over a four year period by a large number of experts in their respective fields. Foreign medical school graduates should be examined because of the lack of acceptable uniform standards in those schools. If, however, an examination is deemed necessary for all those who desire to practice medicine, then I believe that a National Board of Medical Licensure is necessary to insure uniformity of examination. As it is now, even with FLEX, States are permitted to set their own standards for passing or failing and to use questions at their own discretion. I believe the standards should be the same in New York, as in Mississippi or any other State. I recognize that passing a medical examination with a certain grade does not necessarily mean that that person will be a good physician, but some minimum standard is necessary for all the States.

I also believe that it is unnecessary to go through a long procedure and to pay a huge fee to practice in the various States. The Medical Licensure procedure under the States is purely a revenue act or a means of keeping physicians out of a certain State. It is my understanding that nine or ten States will give subjective medical examinations. Obviously, this permits those States to pass or fail any students they so desire for any reason they do desire. I believe that free mobility of medical practitioners throughout the United States with uniform standards is an absolute necessity. Also, if physicians were licensed on a national basis, rather than on a State by State basis, it would cure the evil of having a physician lose his license in one State for incompetence and going across the border and getting a license in another State to practice the same incompetence. Most State Boards of Medical Licensure are political appointees. Even though politics would not be eliminated entirely, if a National Board of Medical Licensure was established, I do believe that it would be minimized because a National Board would not be as reluctant to lift the license of a local colleague as would the State Board. Also, political retribution, for whatever reason, would probably not occur as it does at some State levels now.

Good Samaritan laws have been passed in the various States to encourage physicians to stop at accidents to take care of those injured. These laws, in essence, were not really necessary because the cases where a physician was charged for stopping at an accident and rendering aid were those in which he was charged with practicing medicine without a license in the particular State or territory. State borders have nothing to do with the competence of a physician to practice his profession and should be abolished so that he can freely do so. For these

[9] See also concurrence with entire statement of Howard Hassard and qualified concurrence with statement of Charles A. Hoffman.

reasons, I believe that a National Board of Medical Licensure with national licensing should be instituted and that the primary purpose of such a Board would be discipline.

[The foregoing statement on medical licensure is concurred in by Richard M. Markus and Ella Strother.]

Legal Doctrines

The Commission defeated by a single vote margin a motion that stated, "The Commission recognizes that some courts abuse legal doctrines such as informed consent, res ipsa loquitur, the discovery rule, and oral guarantees, to find strict liability in medical malpractice cases where negligence was not a factor and recommends that state legislatures take remedial action where such abuse of legal doctrines have occurred." After this motion was defeated a substitute motion was introduced and passed by a two vote margin. I dissented on that substitute recommendation because I believe that the pendulum has swung too far in favor of plaintiff's counsel in the malpractice area and courts are finding strict liability by using or abusing legal doctrines which were meant to apply only to negligence cases. The substitute motion, I believe, will open the flood gates of malpractice litigation even wider than at present, if that is possible. I believe that without some limitation placed by the state legislatures on these legal doctrines that the malpractice problem will surpass that of a crisis and become a national scandal. I foresee large numbers of physicians who are past the age of 55 years, who still may have many good years of practice remaining, retiring in order to escape the evil scythe of unwarranted and unjustified malpractice litigation. Many physicians were waiting for this Commission to give them some relief in order to stay in the practice of medicine. That relief has not been forthcoming. As a matter of fact, the physician, by the action of this Commission, will have to serve on more committees, attend more meetings, do more reading, participate in more courses, spend more time in court and have *less* time for his patients.

Even though the maker of the motion indicated that this was not his intention, I am afraid that the passage of this motion will have dire consequences for health care in the United States. Such groups as the American Trial Lawyers Association will argue, in states which are more conservative in applying such doctrines or where legislation is in effect to protect the physician from the unjustified claim or suit, that this Commission was in favor of change to liberalize the law in favor of the plaintiff and this, I believe, was not the intention but I am afraid would be the result. I am in favor of equity on both sides but the pendulum has swung too far and some rationality must be brought to bear before our entire health care system falters under the burden which will result ultimately in harming everyone who is or ever will be a user of health care facilities or providers.

[The foregoing statement on legal doctrines is concurred in by Charles A. Hoffman.]

Consumer Involvement In Non-Federally Funded Research

I dissent from the Commission recommendation that the same degree of consumer involvement be fostered by all appropriate non-federally funded health care delivery and research program because I believe that it will do the consumer more harm than good. I foresee that small family-funded and controlled foundations may decide to divert their health care dollars to other charitable causes if they have to permit someone else to decide where to give the family money in the health care field. I believe the same would hold true for corporations who now contribute to health care institutions including free clinics if they must permit other than the regular management to decide where those charitable dollars should be spent. Some may argue that the word "fostered" in the recommendation is not mandatory but, as so often happens, those who want it to happen will use the recommendation as though it were a requirement. I believe the consumer, who desires so much to set policy in every area today, would be hurt because certain groups who are now giving money for health care projects might decide to divert those funds elsewhere rather than relinquish control to outsiders. Therefore, I believe that this recommendation of the Commission will be more harmful than beneficial to all who benefit from philanthropic contributions to health care either through direct care or indirectly by research.

Implementation Proposal

I voted against the implementation proposal because I believe that this report should be implemented by many diverse groups such as the health care providers and users; the A.B.A., the courts, the state legislatures, the Congress, etc. and that a national organization, committee, or commission, whatever one wants to call it, is not necessary for the implementation of our proposals. I believe it would be a waste of the taxpayers' money to create a lobbying group or a malpractice "czar", as it may turn out to be, for the entire United States when those dollars could be better spent in higher priority areas. I am quite certain there are those who would like to head such a Commission which would receive Federal money but I am not interested in establishing a "Mr. Medical Malpractice". I believe that such an action will only perpetuate the malpractice problem and not quickly resolve it. Any time a full time paid Committee or staff is created in a certain area there are immediate vested interests which will be working to enlarge the scope of the job and who will knowingly or unknowingly perpetuate the very problem they were created to eliminate. This is the history of many areas of our federal bureaucracy.

Dissenting Statement of Paul B. Jarrett, M.D.

The Commission and staff have done yeomen's work in the preparation of this report. Its members have been earnest, sincere, and conscientious. Many of the recommendations are noteworthy, most are helpful, and at worst they are deserving of consideration. I am persuaded, however, that the report has missed the mark and falls far short of alleviating a situation which is hurtful to patients and the physicians who serve them. We have skated about the periphery of the problem but have failed to come to grips with it.

It is impossible to not be sympathetic toward recommendations that call for continuing medical education, for example, but this is not the crux of the problem. All physicians favor elimination of the incompetent doctor, but this is not the crux of the matter either. Neither is failure of access to patients' records; re-certification or re-registration; absence of patients' representatives; or a state Commissioner of Health Consumer Affairs (the latter, in my opinion, would create yet another bureau to share in the health care dollar with little to show for its existence except acrimony on both sides and a gaggle of additional tax-supported jobs.)

The heart of the malpractice problem lies in three directions. One is the invocation of legal doctrines that put the question to the jury without requiring expert testimony that the defendant physician departed from the standard of care in that or a similar community. The second is the tendency by our courts to impose rules of strict liability with warranties of absolute safety and wholesomeness in all things. The third is the use by juries of the physician's malpractice insurance to indemnify patients who have no other source of funds and are in desperate need. However humanitarian this motivation may be, it is not the purpose for which malpractice insurance is carried.

As long as physicians are discriminated against by rules of law that are not applied equally to all segments of society, they must respond defensively, to the detriment of society. The report by inference places the burden of responsibility for the malpractice situation upon the shoulders of the medical profession, yet the profession is confronted with the paradox which says that the more effectively and specifically they treat their patients, the more they are sued and the less is their personal prestige.

The public suffers when the physician is inhibited from utilizing his own judgment, experience and training in an attempt to help his patients. No thinking person would have the courts establishing the standard of practice rather than the medical profession, yet we are dangerously close to this situation.

The report tends to maintain the status quo at a time when health-care providers are pleading for respite from non-meritorious litigation. Hopefully, this report may initiate future action that will reverse the current trend. The delay is regrettable, inasmuch as urgent action was indicated at the time the commission was appointed.

Witnesses at Public Hearings

LOS ANGELES, October 22, 1971

Ralph M. Milliken, M.D., Los Angeles; Los Angeles County Medical Association

Carl Goetsch, M.D., Berkeley; California Medical Association

Edward I. Pollock, Esq., Los Angeles; California Trial Lawyers Assn.

Don Harper Mills, M.D., J.D., Long Beach; Forensic Medicine—USC School of Medicine

J. F. Stay, Burbank; Consumers League on Law and Order

William M. Whelan, Sacramento; California Hospital Association

Edward E. Valiton, Huntington

K. C. Eberhard, Los Angeles; Signal/Imperial Insurance Company

Jack A. Rose, Atty-at-Law, Anaheim

Howard P. House, M.D., Los Angeles; L.A. Foundation of Otology; L.A. County Medical Society

Charles A. Wedesweiler, Jr., Ph.D., South Gate

Robert Maltinsky, Manhattan Beach

John A. Shick, Denver, Colorado; Casualty Indemnity Exchange

Robert C. Lukens, Hartford, Connecticut; Hartford Insurance Company

Thomas G. Moore, Jr., Burlingame; California Council for Health Plan Alternatives

Mark Gorney, M.D., San Francisco; American Society of Plastic and Reconstructive Surgeons

Roger Kaufman, Esq., Phoenix, Arizona; Arizona Hospital Association

LOS ANGELES, October 23, 1971

William K. Scheuber, Oakland; Alameda—Contra Costa

Joseph F. Donovan, Santa Clara; Alameda-Contra Costa Medical Association

James F. King, San Franciso; American Mutual Insurance Company

William J. Hazam, Wakefield, Massachusetts; American Mutual Insurance Company

Frank Saraczewski, Los Angeles

Leo Gelfand, M.D., LL.B., Los Angeles

James L. Rhee, M.D., Oakland; American Society of Anesthesiologists

Julian Rincon, Los Angeles; East L.A. Health Task Force

David T. Cloud, M.D., Phoenix, Arizona; Arizona Medical Association

John Westover, Esq., Phoenix, Arizona; Arizona Medical Association

John C. Allen, Los Angeles; The Nettleship Company

Mrs. Frank Stubenrauch, Inglewood

Robert M. Fox, Esq., Los Angeles; Los Angeles Trial Lawyers Association

Herbert Barr, Van Nuys

Robert Schlens, M.D., Los Angeles; California Medical Association

Miss Zena Foster, Los Angeles

J. J. Daniels, South Gate; Southern California Taxpayer's Council

Mrs. Ray Bellin, Woodland Hills

Mrs. Katherine A. Rau, Carmichael

William F. Quinn, M.D., Los Angeles; California Medical Association

Stewart Knight, Esq., San Francisco; Mobilization for the Un-Named

Mrs. Christina Finlayson, Los Angeles

Maria Bianchi, Los Angeles

Mary Widener, Los Angeles

Marie Cole, Los Angeles

CINCINNATI, November 12, 1971

William E. Hunt, M.D., Columbus

Frank H. Mayfield, M.D., Cincinnati
American Association of Neurological Surgions

Walter Beall, Esq., Cincinnati

Cyril H. Wecht, M.D., J.D., Pittsburgh, Pennsylvania

Miss Cecelia Roemer, Cincinnati

Mrs. Janet Davis, Cincinnati

Robert J. Koch, Detroit, Michigan; Henry Ford Hospital Clinic

Estella Norman, Cincinnati

William Schrimpf, M.D., Cincinnati; Academy of Medicine

K. E. Wallach, Fairborn, Ohio

Charles J. Chastang, Esq., Columbus; Ohio Hospital Association

John W. Pollard, M.D., Urbana, Illinois; Carle Clinic

Ray Brandt, Fort Wayne, Indiana; Medical Safety Consultants, Inc.

Miclos Gulacsy, Cincinnati

Russell H. Volkema, Esq., Columbus; Ohio Academy of Trial Lawyers

William D. McCray, Cincinnati

Mrs. Evelyn Beckman, Cincinnati

Ellie B. Brannon, Esq., Cleveland

Carl Alfred, M.D., Cleveland; St. Vincent Hospital

Phillip Thompson, Cincinnati; American Arbitration Association

Howard Amthauer, Cincinnati

Earl Gilreaph, Covington, Kentucky; St. Elizabeth's Hospital

William Dornette, M.D., J.D., Cincinnati

Joe G. Leibson, Esq., Louisville, Kentucky; Kentucky Trial Lawyers Association

Damon R. Cade, Cincinnati

Stanley M. Chesley, Esq., Cincinnati

John G. Lancione, Esq., Cleveland

Harry A. McNeal, Cincinnati

CINCINNATI, November 13, 1971

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Reuben McCarthy, Cincinnati

Norman Rothermich, M.D., Columbus; Columbus Medical Center

William V. Nick, M.D., J.D., Columbus; Ohio State University

Robert Burkham, Cincinnati

Ben Arnoff, M.D., Columbus; Academy of Medicine of Columbus and Franklin Counties

Walter A. Mischley, Middletown, Ohio; Middletown Hospital

Stephen P. Hogg, M.D., Cincinnati; Midwest Foundation for Medical Care

Garrett Fitzpatrick, Harrison, Ohio

William J. Conroy, M.D., Springfield, Illinois; Springfield Clinic

Frank L. Shively, Jr., M.D., Dayton; American College of Surgeons

Frank F. Pheifer, Esq., Springfield; Illinois State Medical Society

George E. Shambaugh, Jr., M.D., Chicago, Illinois; National Foundation for the Study of Health Science Liability

Lee C. Hess, M.D., Louisville, Kentucky; Kentucky State Medical Association

Roger W. Weseli, Cincinnati; Good Samaritan Hospital

Joseph Atha, Clinton, Ohio

Robert G. Thompson, M.D., J.D., Westchester, Illinois

J. Thomas Allen, Zanesville, Ohio

Mrs. Donald Puccini, Cincinnati

Dr. Robert Price, Cincinnati
—Speaking on behalf of Dr. Audrey B. Norris
Homer Harmon, Cincinnati
Mrs. Elizabeth Key, Cincinnati
Mrs. Lawrence Moser, Cincinnati

WASHINGTON, D.C., December 16, 1971

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